Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 0:52 Medical 4a. Facility Name (if not institution, give street and number **Examiner** or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 1 M 2 XX Age (In vrs. last birthday (Month, Day, Year) Days KOREA Months Min Director 81 217.78.1161 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits the M-diral Examiner must be notified at **Funeral Director** 1 Yes 2xx No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a 22 ST. AGNES RD 21060 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give Specify: Specify: 3 Widowed 4 Divorced ASIAN Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER 12 OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked of permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ew once. ဂ္ UN NYUN KIM **CHANG KYU** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 22 ST ACNES RD. GLEN BURNIE, MD 21060 JINA KWAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **CLEN HAVEN CEMETERY** 11.17.2010 CLEN BURNIE, MD 21. Signature of Funeral Service License FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW CLEN BURNIE CRECORY FINK M01148 MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or reppiratory arrest, snock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Prisician/ nset and Death dical Due to (or as a consequence of) Examiner CAL EXAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): APP attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗌 No မ 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 110 1 Yes 18:00 123 Fall down after deat Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours a Funeral D Agnas Ra Glen Burnie MD 21060 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Tipleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) he 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NNV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LE Vovem bez ANTHONY 20.30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARUNde Baltimore Washington Medical Center GLEN Burnie ANNE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Days Hours Min. 09-24-1946 Mary Land Director 217-50-8191 64 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Anne Arundel Severn 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1666 Disney Road 21144 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Army & Air Force Exchange Service Elementary/Seconday (0-12) College (1-4 or 5+) 8 Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Frank Pleyo, Sr. Blanche V. Haggerty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine C. Pleyo / Wife 1666 Disney Road Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XI Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 11-15-2010 W. Odenton, Maryland ²² Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1711 Appapolis Road Odenton, Maryland 21113 21. Signature of neral Service cense Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TAMPONADE Onset and Death Immediate Cause (Final ERICARDIAL Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EFFUSION PERICARD WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): VIRAL Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant
Unknown Pregnant at time of death 5 Other (specify) Day signed by the a 1 ☐ Yes 2 ☐ Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPER CITO Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 XNo cate has page 2 s this certificate 1 ☐ Yes 2 ☐ No : After this certifica e funeral director, p 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📈 No 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury neral Director: A death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined To the Hospital within 24 hours a To the Funeral Completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number nalled 006509 a NOVEMBER 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE, GLEN BURNIE 21061 JANAKI DEEPAK. 301 22. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Leonard Polanowski, Sr Month Physician/ J. November 2010 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6940 Bank Street Baltimore Co. Baltimore Co. Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) eb. 5,192 Country)
Maryland 216-12-0833 Director 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 No Baltimore Co Baltimore Co 10f Zip Code 10e, Street and Number 10g, Citizen of What Country? 6940 Bank Street Funeral 21224 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver General Motors, 8 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Polanowski Eva Stepczewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Spencer Circle Forest Hill, MD Mr. John Polanowski (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Øak Lawn Cemetery 11/15/2010 4 □ ponation 5 1 Other (Specify) Entembrien Baltimore, MD 21. Si nature of Faral Service Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) ancreati month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dea 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? page 2 should be detached for Year Month Day Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospita Other: 2 🗆 🗖 ٥ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check The detail of the dead of the only one) 29c License number 29d. Date signed (Month, Day, Year) 11]10 35761 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt MD ZIZZ4

Registrar DHMH 17 Rev 7/2009

State

Johns Hopkins

ingelood HD.

32. Registrar's Signature

31. Date filed (Month, Day, Year)

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Director		217-10-0575	^{™ 2} 🖁 F 87	Yrs.	Months Days	Hours Min.	Aug. 23	,1923	Mary	Tand
	show at	1 1	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Maryland Baltimor	e	Towso	n					1 ☐ Yes 2 🂢 No
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	ath wil	Funeral	8304 Carrbridge	Circle 12. Was Decedent Ever in U.	S. 13. V		Hispanic Origin? (Sp	ecify Yes or No-		e - Americ	an Indian,
21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	þ	1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates.	'	f Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Blac Specify:	k, White, 6 Whi	
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nd	filed v d othe event,	To Be	17. Father's Name (First, Middle, Last)	1 _			18. Mother's Nam	, ,			
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time	Page tment o tant: If jury or		4 Donation 5 Other (Specify,	Hi.	lltop S	Service C	orp. 11/1	2/10	Towson,		
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Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs?	3c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fei	tal death 3 🛚	Ectopic pregnan	ісу			te of delive	
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VISI	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural	Route Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.		29a. Certifier 1 Certifying Phys	cian: To the best of my know	vledge, death	occured at the tim	e, date and place, a	nd due to the cau	ıse(s) and mann	er as state	d.
	the Ho nin 24 h the Fur	Medical	only one) 3 Certifying Nurs	er: On the basis of examination of the best of n	on and/or inves ny knowledge,	tigation, in my opin death occurred at t	ion, death occurred a he time, date and pla	at the time, date a ce, and due to the	nd place, and due cause(s) and ma	e to the car anner as st	use(s) and manner stated. ated.
	North Con		29b. Signature and title of certifier	^-		29c. Licens	se number 557(89		29d. Date signed		Day, Year)
			30. Name and address of person who co	ompleted cause of death (Itel	m 23a) (Type F				(1 /(*)		
P			Jam Barron	> 5505 Hay	king /	ay Jim	Circle	Baltin	ve my	2	1224
	Sta Registr		31. Date filed (Month, Day (17)	2010 32. Registrar's Sign	ature A.	faces					

10-08539 Karl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

leen Rotosky		State of Maryland / Department of 1- For State Certificate of		ygiene Reg.	2010	36005
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
dical Exami	ner	Karleen M. Rotosky 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month D November 7	, 2010 4c. County of Death	1658 hrs
		Sinai Hospital	Baltimore			
Funeral Director		5. Social Security Number 218-15-2560 6. Sex 7. Age (In yrs. last birthday) 1 32 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min s.		MM/DD/YYYY) 9. Birth Foreign Cour	MT
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with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 1307 Gatwick Road	10f. Zip Code 21 0 6 0	10g	. Citizen of What Count USA	<i>A</i>
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Karl Bland, Sr.	Li	e (First, Middle, Ma Lnda Cha:	ney	
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State 4 Donation 5 Other Specify:	sition (Name of cemetery, ther place) rematory 11/		20c. Location - City or T Hanover Ma	
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Division of Vital Records, tall or Attending Physician: The law require at Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	1 A Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	1 Yes 2 No	28f. Location (Stror Town, Sta	reet and Number or Rur	ral Route Number, City
Division of Vital Records, P.O. Box 68760, with the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, an ation, in my opinion, death occurred	nd due to the causer	(s) and manner as state	ed. e cause(s)
To To to To to Com	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor.	nth, Day, Year)
		30. Name and a horse of person who completed cause of death (Item 23a)	O.C.M.E.		November 10, 20	710
		20 Decistore Signature	11 Penn Street, Baltimore,	MD 21201		
S Regis	tate		y			
DHMH 17 Rev 1/	2001	ORIGIN	AL	OCME		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edward W. Ridenour Month Physician/ 11/05/2010 $10:58p^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Brooklyn Park MD 4c. County of Death Arundel Examiner Hammonds Lane Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 ☎ M 2 ☐ F 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 4716744 66 215-40-6479 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Brooklyn Park MD Anne Arunde 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral **2**3a 613 Hammonds Lane 21225 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. white 1 Yes 2 No
If Yes, Give
Year or Dates. ō ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 the Nurse Health Care uth and Mental Hygie
27 is marked other
r traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Ridenour Cliffaden Davis 19a. Informant's Name/Relationship (Type, Print)/ Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12 Wallace Avenue, Brooklyn Park MD 2122 21225 Health tem 27 other tem 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State Hanover, 11/9/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Scripture of Fundral S 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc 1501 Fast Fort Avenue, Baltimore MD Trensee Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to by a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, (lo enneupeanon e ae ro) ot euc Examine cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day ned by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes 2 XXV To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica Division of Vital ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2XXNo Certificate: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **XX**atural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 53462 8 MD 2/08/ ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day)

NOV

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of M	aryland / Depa			Mental Hygi	ene		
			State Registrar	Cer	tificate of D	eath		g. No. 2	110, 36007	
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth Rous				2. Date of Death Month いろとつり	Day	Year 3. Time of Death Year 1. 50 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
فممد	>		1 Overlook Lane			altimore		l	None	
	Funeral Director	7	5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 7. Agr	e (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y September	30,1914	9. Birthplace (State or Foreign Country) North Carolina	
	d tow	_	Usual Residence of Decedent 10a. State 10b. County	10c, City, Town or Loc	ation				10d. Inside City Limits	
	arylar a-f sf fied a	cto	Maryland None	,	Ra1	timore			1 🌠 Yes 2 □ No	
	or 28	D I	10e. Street and Number		10f. Zip Code	- CIMOIC	10	g. Citizen of Wh	nat Country?	
	s 23a	Funeral Director	1 Overlook Lane		2	21210		Uni	ted States	
	death items ser m		11. Marital Status 12. Was Decedent B Armed Forces?	Ever in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spon, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X If Yes, Give Year or Dates,	No 1	☐ Yes 2X No	Specify:			White	
Ŏ	hours natur dical	olete	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa		ina 1	6b. Kind of Bus	iness Industry	
21	hin 72 ne. than " e Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5	life DO	O NOT use retired)	-	ing :			
Baltimore, Maryland 21215-0036	d with	a)	17. Father's Name (First, Middle, Last)		Homemal		e (First, Middle, Ma		wn Home	
auc	be file ental I ked o ic eve	일	William Henry Winstead				Privett	ald dir Garrianio)		
ary	nould ind Mi s mar umati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Number, C	City or Town, Sta	ate, Zip Code)	
Σ	id 2 sl salth a n 27 i		James Wilson Rouse, Jr./Son	4537	Blackrocl	k Road, U	pperco,	Marylan	d 21155	
ore	of He If item		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State	20b. Place of Dispos West Arun	sition (Name of patory or other plac	e) Novem	Date 12.	20c. Location - C	Dity or Town, State	
<u>ā</u>	t. Pag tment tant: ijury c		4 ☐ Donation 5 ☐ Other (Specify)	Crematory			2010		, Maryland	
Ba	permit Depar Impor any in	1	21. Signature of Funeral Service Licensee **Distall Exposure** **Note: The service of Funeral Service Licensee** **Note: The s	100672 Do	Name and Addres naldson l	s of Facility Funeral F olis Road	lome & Cr	ematory n. Mary	, P.A. land 21113	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between	
~~	Physician/	1 6		rage CVA					Onset and Death	
_o/.	Medical Examiner		resulting in death) Due to (or as	a consequence of):	Cardiox	rular	Disease			
		ier	Sequentially list conditions.	a consequence of):	C10, 011, 0.41	(30-11)				
y.	ited d ansit	amir	cause, Enter Underlying Cause (Disease or iinjury						()	
<i></i>	execuan and rial-tra	dical Examiner	that initiated events resulting in death) Last C. Due to (or as	a consequence of):						
09	tte be hysici he bu	dica	d							
687	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d Date	of delivery	
XO	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant 2 1 Pregnant 2	2 Fetal death 3 L	Ectopic pregnanc Other (specify)	У		Mon'	•	
B	the de	hysi	9 Unknown							
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ò	Part II. Other significant conditions contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.			oute to the cause of death? 3 Probably 4 D Unknown	
ord	v require been si should b	Completed					24a. Was an		ere autopsy findings available for to completion of cause of	
3ec	he lav ite has	omo					autopsy perform	ned?/ de	eath?	
a	ian: T	Be C	25. Was case referred to medical examiner?			ace of Death (Chec				
Ž	hysic this ce al dire	은	1 Yes 2 No Hospital: 1 Inpat	ent 2 ER/Outpatier		4 L Nursing H	ome 5 Resider			
100	ding F h. After t	ate:	27. Manner of Death 28a. Date of injunction 1 Natural 5 Pending (Month, Date of Injunction)	y, Year) 28b. Time of injury	work	/ at ? Yes 2 □ No	28d. Describe hov	v injury occurred		
SiO.	Attendari ctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inj	ury - At home, farm, stre		103 2 110	28f. Location (Stre	eet and Number	or Rural Route Number,	
Ξ	al or / s after Il Dire		building, et	c. (Specify)			City or Town,	State)		
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of a	examination and/or invest	tigation, in my opinio	on, death occurred a	it the time, date and	I place, and due	to the cause(s) and manner stated.	
	o the o the omple	ž	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	best of my knowledge, o	death occurred at the 29c. License				(Month, Day, Year)	
	F>F0		NSKaj aprinim. D.		000	57465.		11/1	1/10	
	12		30. Name and address of person who completed cause of one of the property of t	leath (Item 23a) (Type, F	Print) Smith A	v -S-20=	3 - Balti	more,	MD. 21209	
	Sta		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature				_		
	Registr	ar	NOV 1 7 2010 Personal	A. Marke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ N & Coth 1 🗗 ay 201°0 7:11 a м Dorothy Mary Rill Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number 7. Age (In yrs. last birthday) 67 yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 43 Country 1 and 6. Sex 8. Date of Birth **Funeral** Hours Min. Selever, Day, Year), 19 1 M 2 X F 213-44-8295 Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Penn. Adams 1 Yes 2 No Hanover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 344 Old Westminster Rd. 17331 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 🕅 Married 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ß Oliver Clinton Grammer Edna Alberta Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is Robert Rill - husband 344 Old Westminster Rd. Hanover, PA. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) New Lutheran Cem. Nov. 19,2010 Manchester, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Hentel 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate gset and Death Immediate Cause (Final Physician/ -Un9 disease or condition Cancel Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform certificate 2 🗆 No 1 🗌 Yes 1 🗌 Yes 2 🔼 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: ျ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Defitying right of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51 32. Registrar's Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 24a per verb., g909-11.1.17/2010dhb
Certificate of Death

Registrar

Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Viola keynolds Movember 2010 10:221 Medical 4a. Facility Name (if not institution, give street 4c. County of Death Examiner Town, or Location of Death of Hospital Sinai Battimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 1 □ M 2 ▼ F Months 217.22.8014 Hours Min. Country) MD Director Yrs. Usual Residence of Decedent ra!", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Oak Baltimore GIVUNI 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 -UKEWOOD 1151 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fire 17 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify: 3 ☒ Widowed 4 ☐ Divorced Specify: Black Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Donnestic Homemaker N Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Hill Cain Hatti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eynolds, uterland Drive Gwynn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Burial 2 ☐ Cremation 3 ☐ Removal from State 11/11/2010 emetery Weedlaws 4 Donation 5 ☐ Other (Specify) Woodlawn Signature of Funeral Service Licensee 22. Name and Address of Facility Valley in C. Cocare Funeral Savies au SLiberty Road Randallstonn HD 202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ evere aort disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner oronar Secuentially list nonditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequenc Hospital or Attending Physician: The law requires that the death certificate be executed angrene To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be (26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation safter death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifie rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only o 29b. Signati 29d. Date signed (Month, Day, Year) HYSICIAN address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ASHINGTON

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV

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Kerrolds

00

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23aPtI,II,25,27,28a-f. per me,g9,12,02/25/2011dhb 1 - For A State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Lharles November 2010 opert /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | | 11 - 13 - 1925 | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 🗆 F PA 204-16-5992 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2X No Carroll MD Westminster Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 505 High Acre Dr., Apt. 21157 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White \$ 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Charles W. Rumbaugh Maude DeLancey ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau William Rumbaugh-son 15 Smith Ave., Westminster, MD 21157 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Lafayette Memorial 11-20-10 Uniontown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee withen D Komas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Complications of Head Injury **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) ERTIFICATION APPROVED BY MEDICAL EXAMINER **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events burial-trar resulting in death) Last Due to (or as a codsequence of) ed by the attending physician and detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Unknown ector: After this certificate has been signed by by the funeral director, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. ģ 2 No 3 Probably 4 Unknown Atherosclerotic Cardiovascular Disease 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 14 Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month. Day Year) 28b. Time of Certification: Injury 5 Pending investigation Matrii al 2 Accident 1 Yes 2 🗶 No Fa11 10/07/2010 Unknown^M within 24 hours after death.

To the Funeral Director: All completely filled in by the fi 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 505 High Acre Dr. 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Westminster, MD Home To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) 29b. Signature and title of pertine License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 CUA 4 LESSANDRO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 1 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0945 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Ger enmore Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** T, Year) 919 1 🗆 M 2 😾 F Months Hours (Month, Mary Tand 91 Yrs 215-10-9498 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified Cockeysville 1 Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 11608 Silvermaple Court 21030 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 K No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo White Specify: 3 X Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Hairdresser permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, II once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cada Roh Barbara John F. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11608 Silvermaple Ct., Cockeysville, MD Barbara Ray-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Baltimore, MD Most Holy Redeemer 11/19/10 4 Donation 5 Other (Specify) Ruck Towson Funeral Home, Inc. owson, MD 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Towson, MD 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-t physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 led by the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 7 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be der þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 12888 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 235M 600a Jembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MINORE If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 X M 2 D F Months Days Hours Country) India Min. **Director** Yrs. 241-92-8597 Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is anarked other than "natural", or items 23a or 28a-f sho important: If tiem 27 is anarked other than "natural", or items 5as or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4181 Lotus Circle 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Asian Indian Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) State Highway 2 should be filed with h and Mental Hygien 7 is marked other th Administration Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Natverlal Bhogilal Shah Ramanben Gauri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nirav Gopal Shah / Son 5278 Grovemont Drive Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Arundel Crematory 11-14-2010 Odenton, Maryland f Funeral Servi / Lice : ee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, 3a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to loi as a consequence on Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown signed by the Hospital or Attending Physician: The law requires that the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by multiple myelomo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? rans plant 24a. Was an renal cate has performe this certificate 2 🗌 No 1 Yes After this certification funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 710153820 University of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 5 Greene 2. Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ November 8,200 1:35 PM Harry C. Schaumloeffel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death cec Remy VA Maryland Health Care Sustem Point Social Security Number 6. Sex 1 **X** M 2 \square F 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Maryland 8. Date of Birth Jan 27, **Funeral** Days Min. , Year 9 <u>25</u> Yrs **Director** 85 215-18-0665 Usual Residence of Decedent 10b. County 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Parkville Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther BLVD. 21234 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married X Yes 2 □ No If Yes, Give Year or Dates. 43 – 45 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Supervisor and Mental Hygie is marked other permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sallie Edwards Harry Schaumloeffel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Lind/Daughter 912Regester Avenue, Baltimore, Maryland 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State LoudonParkCemetery 11-12-10 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael ! maryello 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year ☐ Yes 2 ☐ No 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 taget 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗌 Yes Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA Mursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causes) and manner stated.
3 Certifying Nurse Practioner: To the least of my knowledge, death occurred at the time, date and place, and due to the causes) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 20390 November 82010

Registrar

31. Date filed (Month, Day,

Hoesen, Charles, M.D., VA Manyland Health Care System

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

For State	State of Mar	in Black Indelible Ink. Ens yland / Department of Health Certificate of Death	and Mental Hygiene 2 0	10 3601
. Decedent's Name (Firs	t, Middle,Last)		2. Date of Death	3. Time of Death
ROBERT	WAYNE	SPITLER	Month Day Ye November 10, 2010	1707 hrs

	1- For State Registrar		Certi	ficate of De	ath		Re	eg. No.	10 0001-
Physician	1. Decedent's Name (First, Middle,Last)						Date of Death Month Day Year		3. Time of Death
edical Examine	RODDKI		ITLE				November	10, 2010	1707 hrs
	4a. Facility Name (if not institut 2 Oak Grove Avenue				ty, Town, or Loca tonsville	ation of Death		4c. County of Baltimore	
Funeral Director	5. Social Security Number 8 212-84-5748	/ Mondis Days Hours							Birthplace (State or Foreign
	N/A 1\overline{\text{N}} M 2\overline{\text{F}} 48 Yrs. Worlds Days Hours Will: 02/07/1962 Country) Usual Residence of Decedent								
yna	10a. State 10b. County 10c. City, Town or Location 10c								
* .	MD BA	LTIMORE		CATONS	ZTLLE				1 Yes 2 No
Aaryland 28a-f show	10e. Street and Number 2 OAK GROVE				Zip Code		10	g. Citizen of Wha	t Country?
ith the N	_ - 0 01.011	AVENUE			2122	28		U.S	S.A.
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. traumatic event, the Medical Examiner must be noffied at one. To Bo Completed by English Discrete.	11. Manital Status 1 Never Married 2	12. Was Decedent Armed Forces?	Ever in U.S.		edent of Hispanio				American Indian, Black,
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ars aft tural" mine	15. Decedent's Education (Co	or Dates:	pleted) 1	6a. Decedent's Us	2 X No spe		ork done	Specify: 16b. Kind of Busi	WHITE
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5-0036 led within 72 Hygiene. other than	12			ROOI	FER			CONST	RUCTION
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nore, MD 21215-0036 ages I and 2 should be filed within 7 and 1 Health and Mental Hygene. F. If item 27 is marked other than other traumatic event, the Medical TO By Convent.	ROBERT (19a. Informant's Name/Relation	GLEN SPIT	LER	10h Mailing Addr		ESTHE		CILLE ber, City or Town,	BUZZERD
MD 2 shoulth and 3 is no 27 is no 27 is no 27 is	KAREN SAUERS		1						rx 76002
ore, ME es 1 and 2 s of Health au If item 27 her traums	20a. Method of Disposition			ce of Disposition (Name of cemeter	у,	Date		City or Town, State
More Pages 1 tent of F int: If i	1 Burial 2 X Crematic	n 3 Removal from Sta		matory or other pla VIEW CRI	•	, 11/	15/10	BALTITA	MORE, MARYLAN
Baltimore, permit. Pages 1 at Department of He. Important: If ite	21. Signature of Fleral Service								
0 89 1	Chemi	Of these	#	1907	Í EĂSŤĒ	RN AV	ĖNUĖ, Ė	UNERAL ALTIMOR	RE, MD 21231
Physician /Medic I	23a. Part I. Enter the disease, of failure. List only one cause	e on each line.		o not enter the mo	de of dying, such	as cardiac or	respiratory arre	st, shock, or hear	t Approximate Interval Between Onset and
Examiner	Immediate Cause (Final diseas or condition resulting in death)	a. Diaphrag Due to (or as a conse		Hernia					Death
		b.	quence or):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):						
ed nsit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
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8760, iffcate be g physici s the buri	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes, outcom	e of pregnar			ctopic pregnan	· · · ·	23d. Date of de	
the death certification by the attending ched for use as I Druceirian	past 12 months?	4 Pregnant at t	ime of death			stopic pregnan	icy	Month	Day Year
Bo ne dear	1 Yes 2 No 9 Ur	g Unknown							
P.O.			but not resu	Ilting in the underly	ring cause given i	in Part I.			te to the cause of death? Probably 4 Unknown
day, I				·			24a. Was a		ere autopsy findings available
Records, The law require, ficate has been sig., page 2 should be	<u> </u>						autops	y prid	or to completion of cause of ath?
tal Rec							1 ✓ Yes 2		Yes 2 No
fital sician: is certification.	25. Was case referred to medical examiner?	Hospital: 1 Inpatier		R/Outpatient 3	26 Place of De			Residence 6	Othor Coope
of Ving Physical After this Tool	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28	Bb. Time of Injury	28c. Injury at V	Truising		ow injury occurred	
endin eath. or: A	1 X Natural 5 Pen	(Month, Day,Ye	ar)		1 Yes 2	2 No			
24a. Was an autopsy performed? I V yes 2 No 25. Was case referred to medical examiner? 1 V yes 2 No 27. Manner of Death 1 V yes 2 No 27. Manner of Death 1 V yes 2 No 27. Manner of Death 1 V yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 V yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 28c. Place of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 28c. Place of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 28c. Place of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)								or Rural Route Number, City	
E B E O Normande									
4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)								s stated. to the cause(s)	
L 3 L 3	29b. Signature and title of certifi				29c. License num	nber		29d. Date signed	(Month, Day, Year)
	1 Cayence It	nelknele			O.C.M.E.			November 1	1, 2010
and	30. Name and address of person Margarita Korell MD.	who completed cause of de Assistant Medical E			Street Raltim	nore MD 2	1201		
	manganta reorem MD.	- sociotant Miculoal L		Gill C	Daimii	IVID Z	.201		

State 31. Date filed (Month, Day, Year)
Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 010 Year Physician/ NOV 12 3:34A M Frederick William Spriggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2 □ F 84 214-20-9189 MĎ Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location with the Maryland Director Carroll Westminster MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA Funeral 1163 Old Manchester Rd. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ò 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Optical within 7 Elementary/Seconday (0-12) Optician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Schmidt 2 William Spriggs permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 19a. Informant's Name/Relationship (Type, Print) 1163 Old Manchester Rd., Westminster, MD Faith M. Spriggs-wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 11-17-1d Finksburg, MD 4 Donation 5 Other (Specify) 21. Signaturo funeral Service Licensee 22 Name and Address of Facility Fletcher Funeral Home Street Westminster,Md. Flikhu. homas D Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for es e consequence of: Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Other (specify) the □ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 performed? 24 hours after death.

Funeral Director; After this certificate leted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural
Accident
Suicide
Homicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 [3 [(Check To the I within 2.
To the I complet only one) title of certifier 29c. License number 29b. Signature 10059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700A POULE RO WESTMINSTER MD 2/157 G-OURISHANKAR C. NAUANNY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Dav Month **Physician** 11:30 PM 2010 Scott, Sr. Nov. 10, Richard Franklin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Genesis Heritage Meridian Ctr. Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 🙀 M 2 🗆 F 20,1928 Dec. Maryland 81 Director 218-22-5310 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Examinar must be indified a once. 1 ☐ Yes 2 XNo Director Dunda1k MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 1957 Ewald Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: Korean 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify. White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drywa11 Construction Finisher 6 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Pfarr Andrew Jackson Scott ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21222 1957 Ewald Ave. Dundalk Maryland Ruth Mary Scott (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem.11/15/2010 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CCIDENT **Physician** /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ☐ Probably 4 ☐ Unknown 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 No 1 Yes 25. Was case referre o medical examiner? 26. Plac Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Heath Men 33 (Type Strike) [0 - A

OP 32. Registrar's Signature 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Slater Anthony Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death hty of Death Examiner 8. Date of Birth (Month, Day, Feb 22 yrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 № M 2 🗆 F Months Days Hours Maryland 217-56-9099 59 **Director** Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Director Forest Hill Harford Maryland 1 Yes 2 x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 21050 2414 Grable Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Divorced 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Industry 4 Years Trucking Company Owner 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clarence E. Slater Christina L. Matrazzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Forest Hill, MD 2414 Grable Ct. Mrs. Patricia A. Slater(Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 11/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. tanl 21222 Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) a consequence of) FIBRULATION Examiner <11h AIRIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) HYPERTENA attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Yes 2 No. 1 ☐ Yes 2 ☐ Unknown nas been signed by the e 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Goul autopsy within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page death? 1 ☐ Yes 2 ☐ No 2 1 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗷 Natural $5 \square$ Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-11 2014 24276 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon Scalia 2801 Hudson ST Balto md 21224 32. Registra State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 7, 8, & 15 per FH, G909, 11/23/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Mildred Mary Alberta Sipperly 4:55 Рм 14. 20**T**0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Baltimore The Villa Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec . 10, 1916 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Month, Day, Yearly 1947 Country) Work 1 □ M 2 🗓 F Months 63 93 Yrs. 128-12-0360 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10a. State 10d. Inside City Limits 72 hours after death with the Maryland 1 ☐ Yes 2 X No Baltimore Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6806 Bellona Ave. 21212 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mer College (1-4 or 5+) Elementary/Seconday (0-12) church ministry religious order Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emma Harnett Albert Sipperly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21204 1001 W. Joppa Rd. Sr. Loretta Cornell, MHSH/guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemeter Nov. 19,2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 16500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee 23a. 94rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ancer-₽nysician/ 0/01 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it arry, leading to in insolute cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Detrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 11/16/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMOUD Rida 32. Registrans Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Stockton 40 AM Nyonthuber Physician/ 5) Reginald 2000 Medical 4a. Facility Name (if not institution, give street and number)
Loch Raven Community Living (4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Hours Min. 1 🔀 M 2 🗆 F Months Director 9-24-1943 PENNA 182-34-3283 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 28a-f MD. N/A BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ems 23a or r must be r Funeral 9 W. CHASE ST. APT. 21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status "natural", or iten edical Examiner r Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MYRECK COM SALES Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental WILLIAM J. STOCKTON 2 LOUIS JOHNSON of Health and Menta item 27 is marked other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID STOCKTON (BROTHER) 3920 GREEN ST. HARRISBURG, PENNA 17110 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 🗌 Burial Crer 5 🗆 g ation 3
Removal from State 4 Donat ther (Specify) METRO CREMATORY 11-15-2010 BALTIMORE, MARYLAND D. HIBNER2. Name and Address of FacilityPHILLIPS FUNERAL NAHTANOL HOME, P.A. 21. Signat 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Parli Approximate k, or heart failure. List only one cause on each line. Interval Between Metastatic Onset and Death Immed the Cause (Final diseas for condition resulting in death) ancer Colon Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to or as a conse uence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Veal Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗆 Yes 2 🛂 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSPICE 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? s after dea... Natural 5 \square Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D41365 no IM

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

och Kaven

Battimore

Boulev

Mary (and

21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helmi Ilona Sweeney November 8:50 Рм 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2806 College View Rd. Churchville Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Hours Min. May 1 Day, 98 Year 912 032-10-0311 Director Massachusetts Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Maryland | Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2806 College View Rd. USA 21028 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
raumatic ever Herman Oscar Mattson Ida Maria Jaarvinen permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Kaplan / Daughter 2806 College View Rd, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/15/2010 4 ☐ Donation 5 🛛 Other (Specilian tombment Harford Mem. Gardens Aberdeen 21. Signatur Friends Tarring-Cargo Funeral Home, P.A. 333 S. Parké St. Aberdeen, MD 21001 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ cerebro Jascular occident one year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2- No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform death? eral Director: After this certificate I filled in by the funeral director, pag 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ē 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work Certifica 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description:

D 29a Certifier (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) thalle, mD 11/10/10 000049050

Registrar

DHMH 17 Rev 7/2009

State

Suchery

S. Parke

St. #400 Abesdeen MD 21001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shukla

Plashant

31. Date filed (Month, Day, Year)

4.0.15

32. Registrar's Signature

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			For State Registrar	State of M		artment of Health and rtificate of Death		giene Reg. No. 2 () (36021
	Physici	an	Decedent's Name (First, Middle,	Last)			2. Date of Dea		3. Time of Death
dia.	/Medic	cal	Lillian D. 4a. Facility Name (If not institution,	Spie		4b. City, Towny or Location of Dea	Morsento	4c. County of Dea	
	Examir	ier		WERSIDE		BEL CAI	np	HARA	Tiel
	Funeral Director		5. Social Security Number 215-12-8934	. Sex 7. Aq 1 ☐ M 2 💢 F	ge (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		^h (year) 9. Bi 2, 1921 Ma	therace (State or Foreign ountry)
	σ		Usual Residence of Decedent		10c. City, Town or Lo	cation	041)21	-, -, -, -, -, -, -, -, -, -, -, -, -, -	10d. Inside City Limits
	Maryla -f shov ied M	tor	10a. State 10b. County Md. Balti	more	Roseda				1 ☐ Yes 2 🛣 No
	filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be notified at	by Funeral Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	ountry?
	eath w	eral	1315 Chesaco	Avenue	Ever in U.S. 13	21237	Specify Yes or No-	U.S.A.	erican Indian.
9	or item	/ Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces	No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □Yes 2□No <i>Specify:</i>	rto Rican, etc.)	Consitu	te, etc.
21215-0036	hours tural",	ed by	3 Widowed 4 □ Divorced 15. Decedent's	Year or Dates:		dent's Usual Occupation		Specify: W	hite //Industry
215	thin 72 re. an "na	Completed	(Specify only highest	College (1-4or	(Give	kind of work done during most of wo DO NOT use retired) me Maker	orking	Own Home	•
d 21	iled wil Hygien ther th nt, ine		1 Z U D 17. Father's Name (First, Middle, La		по		me (First, Middle,	Maiden Surname)	
lan	Aental rked o	To Be	Bernard Demi				ne Feda		
Baltimore, Maryland	12 shouh and N is ma	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address <i>(Street and Number or F</i> Bauernschmid	Rural Route Numbe	er, City or Town, State, Baltimor	Zip Code) e.Md21221
re,	t Healt Healt Hem 27 other 1		20a. Method of Disposition				/ Patriber	20c. Location - City o	
imo	Pages ment o ant: If i ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☑ Other (Sp		t St.Stan	islaus Cem 1	7,2010	Baltimore	,Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liviny or other traumatic event, I've Medical Examinar must be notified at once.		21. Signature of Funeral Service Lie	censee	2 22	2. Name and Address of Facilitk a c	czorows venue B	ki Funera altimore,	1 Home, PA Md. 21222
Too.	Physician		23a. Part 1. Enter the disease or conshock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cause by one cause on each I	d the death. Do not en	ter the mode of dying, such as cardi — — — — — — — — — — — — — — — — — — —	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
and a	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				weeks
	B +	ner	Sequentially list conditions, if any, leading to infried ale cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dun to (or or	a consequence offi				
	e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	ars			-year)
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x 687	death certificate t attending physic I for use as the b	Med	IF FEMALE:	22a If you guttoom	of programou				
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 ☐ Fetal death 3 [Ectopic pregnancy Other (specify)		23d. Date of d Month	Day Year
ords, F	w requires that the de been signed by the should be detached t		Part II. Other significant condition	s contributing to death I	out not resulting in the u	nderlying cause given in Part I.		obacco use contribute Yes 2 □ No 3 □ I	to the cause of death? Probably Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law n within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Completed by	-				24a. Was autor perfo 1 □ Yes	osy prior to rmed? death?	autopsy findings available completion of cause of s 2 □ No
Vita	sician certific irector,	Be	25. Was case referred to medical examiner?	Hospital:	ient 2 ☐ ER/Outpatie		eath (Check only o	<i>ne)</i> dence 6 □Other <i>(Sp</i>	- 16 A
n of	ng Phy fter this meral d	Certification: To	27. Manner of Death Natural 5 Pending	28a. Date of Inj (Month, D		f 28c. Injury at Work?		how injury occurred	еспу)
isio	Attendi death. ctor: A y the fu	ficati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 280 Place of In	jury - At home, farm, st	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or i	Rural Route Number,
Ō	tal or / rs after al Dire ed in b	Certi	4 ☐ Homicide determin	building, e	tc."(Specify)	· ,	City or To	vn, State)	
	e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best caminer: On the basis and manner s	of examination and/or ir	h occurred at the time, date and pla evestigation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and de	as stated. ue to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifler	w)		29c. License number		29d. Date signed (Mod	nth, Day, Year)
			30. Name and address of person w	no completed cause of	death (Item 23a) (Type	Print)		11/12	
			PATRICIA	DUBYSI	4 65	W. Marphael 1	I bel A	47 MO 21	1014
	Sta Registr		31. Date filed (Month, Day, Year)	2019 32. Regard	rar's Signature	face			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ac 655 Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 50 altimore ento . Age (In yrs If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔊 Months Hours Min Day Country) **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 D yes 2 D No HMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23 1a Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 NO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: nd Mental Hygiene. marked other than "natural", 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Mother's Name (First, Middle Maiden Surname) မ of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number H More MD other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot cemetery, crematory Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses tolu zitimae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Filysician/ ance disease or condition resulting in death) CRT Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or as a conse gience of the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown after death.

Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy perform Yes in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **K** No ျ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Accident Investigation ☐ Accider ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

36023 State of Maryland / Department of Health and Mental Hygiene 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D10, <u>2010</u> Physician/ November Joyce Eileen Thomas 11:57 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Mar. 5, 1954 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Maryland Director 219-60-3671 56 Usual Residence of Deceder show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 Jessica Lane 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 - Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Tool Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clifton William Thomas Sr. Dorothy Mae Beasley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7903 Orion Circle, Laurel, MD 20724 Kevin D. Thomas / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp: 11-15-10 Towson, Maryland 22. Name and Address of Facility

McComas Funeral Home, P.A. 21. Signature of Funeral Service Ligense ma 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications this lease the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ bladder disease or condition KNUM Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transi Kunetobac Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy perform 2 No Yes Vita director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Curtifying Nurse Fractioner: To the best of my knowledge, death persured at the time, date and place, and due to the causelet and many area stated 29b. Signature and the of certifier 29c. License number D0065421 November 11, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive Bel for Manyland 21014 Christa Fisher WD 500 upper 31. Date filed (Month, Day, Year 32. Registrar's ignatu Registrar

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AMEND ITEM#10c, perFH, G909, 117, 7/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** INNIE 0500 NOVEMBER 12 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TURNER STATION 537 NEW PITTSBURG AVE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Yrs. Director MAY 3, 1927 MD 83 214-22-1209 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Turner Station r 28a-f sh notified a 1 Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe a USA ral", or items 23a Examiner must t 2122**7** 537 NEW PITTSBURG AVE Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 Widowed 4 ☐ Divorced Year or Dates: "natural" BLACK er than "natur , the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FLEMING SENIOR CNTR. SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be HERBERT SHARPE, SR. ို ELLA L. YOUNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA BANKS/SISTER 537 NEW PITTSBURG AVE, BALTIMORE,MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GARRISON FOREST 11-22-10 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 0 1701-31 LAURENS ST., BALTIMORE, MD 21217 23a. P 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, struck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending phys for use as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 THROMBOSIS 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed THROM BOSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of funeral director, rage 2 autopsy performed? Yes 25 No death? 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**⊡***No Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

n State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jennifer

30. N Ime and address of person who completed cause of death (Item 23a) (Type, Print)

5505

32. Registrar's Signature

Hayashi

DHMH 17 Rev 1/2001

29c. License number

D62032

Hopkins Bayview Circle Balto., MD 21224

29d. Date signed (Month, Day, Year)

NOVEMBER

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ USE IA N Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) 8. Date of Birth (Month, Day **Funeral** Hours Min. Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If fire 27 is marked other than "nature" any injury or other terms. 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 No 10g, Citizen of What Country? Funeral 5 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 🗌 Yes 2 X No Specify: Completed 3 Widowed 4 □ Divorced BLRCK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ENDR 20b. Place of Disposition (Name of cemetery, crematory or other place, 11-19-200 BRITIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licensee 22. Name and Address of Facility LE DERRICK C. JONES FIH, P.A. HGTS. AUE. BALTIMORE, MARYIAND ons that caused use on each line 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca et caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 2 No 1 Yes Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 \square Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deaf Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year NOV 17 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nonth 5 Medical 4a. Facility Name (if not institution, street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death altimare 10 Kandall town Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕏 Hours Country) Director Usual Residence of Decedent shov 10a, State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director other traumatic event, the Medical Examiner must be notified More 23a or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) neral Service Licens Sign ture 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac 🛭 respiratory arrés Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a cor equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First Unitedlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been slaned by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Be Completed 1 Tes 2 🔲 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural injury 5 Pending 1 Yes 2 No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature License numbe

State Registrar ss of person who completed cause of death (Item

filed (Month, Day, Year)

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#5, 17 18, per FH, G909, 11/17/2010, WS.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Woodrum Physician/ Month ZOI 0 oro the 7:45 Medical acility Name (if not institution, give street Examiner Town, or Location of Death 4c. County of Death HIMORE Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if filem 27 is marked other than "natural" any injury or other traumatic event. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 rowson USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 L Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 □ Divorced Klack 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Glive kind of work done during most of working life. PO NOT use retired)

Mail Klum Supurvisor Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ၉ Robert Chambers Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb Son Woodrum Hurcel. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral ervice linensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Utiny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence tern Diabelm To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 2 No Yes 2 No 1 L Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **N**o 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 \square Pending iniury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 921088 Than Poor, mi 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #601 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla	and / Dep	artment of l	Health and	Mental Hy	giene		
			= State Registrar		Ce	rtificate of	Death		Reg. No.	10 2000	
-	Physicia Medi		1. Decedent's Name (First, Middle, Las	Watsor	7			2. Date of De Month	ath C Yea	3. Time of Death C	
40	Exami	ner		street and number) Hos	PITAL	4b. City, Town, o	Location of Dea		4c. County of De		
	Funeral Director		000 00 3710	PX 7. Age (In yrs. ☐ M 2 F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		th (9. E	Birthplace (State or Foreign Bountry) Pary Gno	
	aryland a-f show fed at	ctor	Usual Residence of Decedent 10a. State 10b. County N/A		City, Town or Lo Baltim					10d. Inside City Limits	
	th the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number 1511 N. Luz	erne Ave		10f. Zip Code	212		10g. Citizen of What	1X Yes 2 No	
٠.	r death w or items 2 niner mus		11. Marital Status 1 Never Married 2 XMarried	12. Was Decedent Ever in L Armed Forces?		Was Decedent of H	213 ispanic Origin? (i an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	USA 14. Race - An Black, Wh	nerican Indian,	
-0036	nours afte atural", c cal Exam	eted by	3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates.		1 Yes 2 No			Specify:B1	ack	
21215	within 72 ł giene. er than "n the Medi	Completed	(Specify only highest gra Elementary/Seconday (0-12) 12th	College (1-4 or 5+)	(Give	kind of work done of NOT use retired)		orking	16b. Kind of Busines Lord Ba Laund	ltimore	
land	d be filed of the filed of the fire of the fice event,	To Be	17. Father's Name (First, Middle, Last) William Dow	- A1 / AA			18. Mother's N	ame (First, Middle,		± y	
Man	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Ty George Watson/		19b. Maili 1 5 1 1	ng Address (Street	and Number or F	Rural Route Number	; City or Town, State, 2	Zip Code) 21213	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi	Removal from State	cemetery, cre-	osition (Name of matory or other place n Fores	t 11,	Date /23/10	20c. Location - City of		
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service License	Betts	1	2. Name and Addres	ss of Facility Be	etts Fur ne St. I	neral Hom Balto.,MD	ne 0 21213	
7	Physician/	`	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	lications that caused the deale cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory arm	est,	Approximate Interval Between Onset and Death	
	Medical Examiner	_	resulting in death) Due to/(or as a consequence of): Due to/(or as a consequence of): Due to/(or as a consequence of): Due to/(or as a consequence of):								
	uted od	Examiner	if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury that initiated events	Due to for as a consec A LZ here	quence of): Mel 5	Disa	use				
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. Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnand Other (specify)	у		23d. Date of d Month	elivery Day Year	
s, P.O.	ires that the signed by detaction	ρ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	ınderlying cause giv	en in Part I.			to the cause of death?	
Division of Vital Records,	e law requires has been ge 2 shoul	Completed						24a. Was a autops perfor	n 24b. Were a	utopsy findings available completion of cause of	
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<u> </u>	nysicia lis cer I direct	일	examiner? 1 Yes 2 No	lospital:	BR/Outpatier	Othe			ence 6 Other (Spe	cify)	
on of	ending Pl sath. or: After th he funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	at		w injury occurred		
DIVISI	ital or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	nome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or Re n, State)	ural Route Number,	
	the Hosp hin 24 hou the Funer upleted fil	Medical	only one) 3 Certifying Nurse	cian: To the best of my know er: On the basis of examination Practioner: To the best of m	on and/or invest	igation, in my opinio	 death occurred 	at the time date an	d place, and due to the	cause(s) and manner stated	
	ତ ହୁ ଜୁ≇ ଦ		29b. Signature and title of gertifier	CRNP		29c. License			9d. Date signed (Mont		
			30. Name and address of person who co	honey CAN	m 23a) (Type, F	rint) Pom C	1000 8	E. Eage	8t. Bak	110 to:Md.z1202	
	State Registra	-	31. Date filed (Month, Day, Year) NOV 17 2010	32. Registrar's Signa	ature						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Leroy Weinzirl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HAR. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 □ F 217-22-9447 84 Director 29,1926 Maryland June Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f st traumatic event, It e Madical Exprimer must be notified Director Harford Maryland 1 ☐ Yes 2 X No Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Glenville Rd 21028 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married WEINZIRL Baltimore, Maryland 21215-0036 If Yes, Give 1944-45 Year or Dates: 1 ☐ Yes 2 🟋 No Specify: þ Specify.White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the once. 12 Civil Service Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Weinzirl Mildred Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Broad St., Perryville, MD 21903 Larry Weinzirl / Son 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Wher (Specify Entombment BelAir Mem.Gdns 11/19/2010)
Signature of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place)

1 Burial 2 Cremation 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

1 Signature of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Tarring-Cargo Funeral Home, 333 S. Parke St, Aberdeen, Denies 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asplywhon **Physician** Mahmonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner wmun When Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of Physician: The law requires that the death certificate be executed Vicheny MEUTUS burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Ulusmi Uhrrhma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed ,24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No has 24a, Was an this certificate 1 □Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: All Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death After t 28b. Time of 28d. Describe how injury occurred or Attending 1 Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Win (M 31. Date filed Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sandra 116 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Days Months 73 219-26-1152 Marviand Yrs. Director Nov Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Medical Examiner must be notified Baltimore MD Baltimore 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a Funeral 1844 Glen Ridge Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: Completed 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilfred Patterson Ruth Feldmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17427 St. Theresa DR., Olney, MD Heather W. McIntyre-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State Hilltop Serv Corp 11/17/10 Towson, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service censee William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Yes 2 XNo ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special Control of the Control 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 Yes 2 No M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number Cit. comp R125808

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State Registrar

rar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anne Le

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State of M	1arylan	d / Depa Cer	artment of I tificate of L	Health and Death	d Mental H	lygien Reg. N	e2010	3603	3
	Physicia	an/	Decedent's Name (First, Middle, Landson LOUIS		AGE				2. Date of Month	Death	Pay 11, 2010	3. Time of Deatl	
-	Medic Examin		4a. Facility Name (if not institution, giv				4b. City, Town, o	r Location of De			c. County of Death	1:23 P	IVI
and the same			Bowie Health Camp	<u> </u>			Bowie				Prince G	eorge's	
	Funeral Director			Sex 1 □ M 2 XX	ge (In yrs. la 71	ast birthday) Yrs.	If Under 1 Year Months Days	Hours M	lin. 8. Date of I (Month, July	Birth Day, Year) 18 •	9. Birth Cou 1939 Was	nplace (State or Fore ntry) nington,	-
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larylan	a-f sh ified a	ecto	Maryland Howard			urel	ation					1 Yes 2 😾	
the M	a or 28 be not	į	10e. Street and Number			4101	10f. Zip Code			10g. C	Citizen of What Cou		
th with	ns 23g must b	Funeral Director	10637 Whiterock (2072				S.A.		
NUSO Irs after dea	ıral", or iter Examiner	è	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ XXvorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates.	?	If	Vas Decedent of H Yes, specify Cuba	ın, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Amer Black, White Specify: W		
DEALLITIOTE, INIGITYICALLY LA IS-UUSO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rivury or other traumattc event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			working	16b. Kind of Business Industry University of Maryland				
Illed w	al Hyg	Be	17. Father's Name (First, Middle, Last)			2002	7	18. Mother's I	Name (First, Midd				
yland Jid be filed	Menta narked natic e	욘	Albert N. Beards					Flossi	e Galimo	re			
2 shot	Ith and 27 is n r traum		19a. Informant's Name/Relationship (David A. Yescavac				g Address (Street a Whitero				or Town, State, Zip	Code) 20723	
Ore, le 1 and t of Hea If item or other	of Hea fitem rothe		20a. Method of Disposition 1 XXurial 2 Cremation 3	,	20b. P	lace of Dispos	sition (Name of eatory or other place		Date	_	Location - City or 1		
Dalumor permit. Page 1	tment rtant: I njury o	1	4 Donation 5 Other (Spec	cify)	-	ional	Memorial	Park 1			alls Chu	rch, VA	
permi per	Depar Impor any ir		21. Signature of Funeral Service Licer		770		Domarkaso: 313 Talb				Marylan	i 20707	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each lir	d the death	n. Do not ente	r the mode of dyin	g, such as card	liac or respiratory	arrest,		Approximate Interval Between	
	ysician/ Medical	6 0	Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of):									Onset and Death	
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the death o	within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	1 Live Birth 4 Pregnant a 9 Unknown	2 🔲 Feta at time of d	I death 3	Ectopic pregnand Other (specify)	Э́У			23d. Date of deliver Month	Day Year	
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w requires	s been shoul	Completed	Coronary Arter	cy Disease					24a. Wa	as an	24b. Were auto	psy findings availab	ble
The la	page (Com							pe	topsy rformed? s 2 X X N	death?	ompletion of cause of 2 🔀 🏋	JI
siclan:	certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒️Xo	Hospital:	- ¥		La	ace of Death (Co					
g Phys	er this neral di	te: To	27. Manner of Death	1 ∐ Inpat 28a. Date of inju (Month, Da	ury	ER/Outpatient 28b. Time of	28c. Injury	4 ∐ Nursing ≀at	g Home 5 Re 28d. Describe		6 Other (Specifing occurred)	/)	
tendin	tor: Aff tor: Aff the fur	Certificate:	1 XX atural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	on le		injury		Yes 2 No					
alorAi	s arrer o		4 Homicide determined				et, factory, office			(Street ar own, State	nd Number or Rura e)	I Route Number,	
the Hospit	the Funera	Medical	(Check 2 Medical Examonly one) 3 Certifying Mar	vsician: To the best of niner: On the basis of e rse Practioner: To the	examination	and/or investi	gation, in my opinic	n, death occurre	ed at the time, date	e and place	e, and due to the ca	use(s) and manner s	tated.
2	To Con		29b. Signature and title o certifier	11			29c. License	number 3235			ate signed <i>(Month,</i> vember 1:		
	1		30. Name and address of person who	completed cause of c	death (Item	23a) (Type, Pr				110	V GIIIDEL I.	2, 2010	
	1		Dr. Darryl Hill,	M.D. 136	35 Ba	ltimor	e Avenue	Laure	l, Maryl	and	20708		
	Stat Registra		31. Date filed (Month, Day, Year) NOV 17 2010	32. Registr	ar's Signati	parks	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36032 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0103 м Physician/ Mailliam Buenbe Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death COUNTY Hosni Merstown If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** . Age (In yrs. st hirthday g. Birthplace (State or Foreign Months Hours 217-30-6424 7.3 Director Nov Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f si other traumatic event, the Medical Examiner must be notified. MD Washington Hagerstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18707 Preston Road 21742 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 - Widowed 4 - Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clyde Abrecht Sr. Wilmoth Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Abrecht (wife) 18707 Preston Rd., Hagerstown, MD, 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Smithsburg Crem. 4 Donation 5 Other (Specify) 11/9/2010 Smithsburg, MD Signature of Funeral Service Licensee Keeney & BasTord P.A. Funeral 106 E. Church St., Frederick, Funeral MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE for use a yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Dav signed by the a 2 No 1 ☐ Yes 2 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should DUIMONDIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No CORONARY Artery Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred o medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital! မ Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

State Registrar only one)

29b. Signature and title of certifie

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

DHMH 17 Rev 7/2009

s Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 1008AM 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner natimore en 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Months **Director** Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a State Director Monkton 1 Tes 2 No HIMOV 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 2111 130,5/81 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) SANITARY SERVICES Collection Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 eulah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KUHI Rd ta Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) reduny 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 100 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No sate has been signed by the atte page 2 should be detached for Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ♣ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ans

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State Registrar 31. Date filed (Month, DAL)

DK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ John, A, Butler Oct 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 2 Baltimore University Maryland Medical If Under 24 Hrs 8. Date of Birth Year 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Months Days Min Jan 29 Year 942 Marvland 219-40-0381 68 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Odenton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1224 B Scotts Manor Ct. 21113 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or à 1 Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2X No Specify. **Black** Specify: Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6th 0 Sanitation Worker City of Annapolis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be filed hand Mental H marked Rachel Downs William Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.e</u> of Health a Tora Wright(Daughter) 3015 Elsa Ave Waldorf, Md. 20603 Baltimore, 20a. Method of Disposition 20b. PIBe Solspostot Came of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it ₽ 1 X Burial 2 Cremation 3 Removal from State memorial Park injury or 10-30-10 Annapolis, Md. 4 Donation 5 Other (Specify) Williame a Broad Sector Facility Sons Mortuary, P.A. Signature of Funeral Service Licensee Š 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Intra-abdonina one week Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗆 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 1841425592 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Greene St.

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Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John R. Blackburn CLM taber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Plata Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Country) N. Carolina **Funeral** Months Days Hours Min June 12 1 🕸 M 2 🗆 F 243-28-9864 85 Director Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Charles 1 Yes 2XX No Charlotte Hall 10e Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 29449 Charlotte Hall Rd. 20622 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: Completed 3X Widowed 4 ☐ Divorced Baltimore, Maryland 21215-00 Black WWII 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Reuben C. Blackburn Mary Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard A. Tabor / Nephew 2018 Cambridge Dr., Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/29/2010 Wilkesboro, NC 4 ☐ Donation 5 ☐ Other (Specify) Highview Cemetery 22. Name and Address of Facility Beall Funeral Home 21. Signatury of Funeral S 6512 NW Crain Hwy., Bowie, MD 20715 23a part 1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) *j* Medical Examiner Sequentially list conditions Examiner Due to (or as a cor if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit that initiated events Due to (or as a consequence resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23h Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 2 🗌 No be detached 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an pade 1 Yes 2 No the funeral director, Be 25. Was case referred to predical 26. Place of Death (Check only one) Hospital Other: 2 No 욘 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniun 5 Pending 1 Yes 2 No Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 20 Name and address of person who completed cause of death (Item 23a) (Type, Print) Post Office

DHMH 17 Rev 7/2009

Registrar

2 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9:57 AM Physician/ Elizabeth Veronica Bujak 0 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 2717 Old Ocean City Road Salisbury If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** $Ma_y^{Month}, Day, 1^{Year}$ New Jersey 89 155-07-5969 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Wicomico 1 Yes X No Maryland Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code items 23a Funeral 2717 Old Ocean City Road 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) ö þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give Specify: White "natural" Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 P Health and Mental Hygiene. tem 27 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Elemetary School Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Veronica Shea Milton Brooks Faunce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lydwina Diemel/Daughter 2717 Old Ocean City Road, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 X Removal from State Asbury UMC Cemetery 10/30/2010 Cinnaminson, NJ 4 Donation 5 Other (Specify) 21. Signature of uneral Service Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, sevence MD 21802 23a . Dert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAMBN TA Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) -transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? be detached for 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Affection 6 Other (Specify) Hospital: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending n 24 hours after death.

e Funeral Director: After sleted filled in by the fun Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24 only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strikely up 2/802 3> WARY 6 Hurton 13UP

Registrar

State

31. Date filed (Month, Day, Year)

OCT

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10728/2010 Physician/ 4:04 P Charles Edward Burr, Jr. Medical 4a. Facility Name (if not institution, give street and number, or Location of Death 4b. City, Town, 4c. County of Death **Examiner** 13e) 6108 Kes da Court Leer 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Washington, DC 0170671925 Director 85 579 18 1726 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 6108 Dunleer Court 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: and Mental Hygiene. If Yes, Give 3 XWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Montgomery County Tax Assessor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles Edward Burr Dorothy Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jermit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Coral Sea Drive Rockville, MD Marilyn Burr Rossie/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/04/2010 Washington, DC Oak Hill Cemetery 22. Name and Address of Facility Joseph Gawler's Sons, Inc. Signature of Funeral 20016 5130 Wisconsin Ave., NW Washington, DC 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) 940 Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown phone 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy this certificate 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Normalize} \) Other (Specify) 1 Yes 2 ☐ No ြုင 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury od 28c. Injury at Certificate: After 5 Pending 1 Natural work? 1 ☐ Yes 2 🕅 No Unt PM Investigation 52 50ho Accident within 24 hours after deatl

To the Funeral Director:

completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office Cay Linbuilding, etc. (Specify) 28f. Location (Street and Number or Runal City or Town, State) Homicide determined Strpe Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prijstical: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionery to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **KCheck** only one) 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) (5 1000428 mo DMG 524 Kankesbur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2010 Physician/ William November 2 Butler Jr. Robert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's St. Thomas More Nursing Facility Hyattsville 8. Date of Birth (Month, Day, 01/17/1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Washington, DC Months Hours Min. /1939 578-50-5360 Director Usual Residence of Decedent nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland Prince George's Clinton 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7400 Berkshire Drive 20735 USA Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 X Married XX Yes 2 No 1959-Maryland 21215-0036 1 Yes 2 No Specify: **Black** Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1965 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tractor-Trailer Driver Food Industry 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ William Robert The 1ma Butler Mae Savov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Berkshire Drive Clinton Mattie Louise Butler / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once. XX Burial 2 ☐ Cremation 3 ☐ Removal from State 11/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cemetery Cheltenham, Maryland Signatury of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician, END STAGE RENAL DISEASE disease or condition resulting in death) vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires unature we within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia Division of Vital Records, 1 Yes 2 No 3 Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? Encephalopathy 4 contract the contract of the 24a. Was an autopsy performe 1 🗌 Yes _2 🗌 No 1 ☐ Yes 2XX No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X XNo 2 1 Inpatient 2 ER/Outpatient 3 IDOA XX Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1XXNatural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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State Registrar (Check

only one)

3 🗌

Paul A. DeVore

31. Date filed (Month, Day, Year NOV 0 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

November 2, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4203 Queensbury Rd. Hyattsville, Maryland

29c. License number

D01852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yea **Physician** 3:15 P M LARRY FITZGERALD BROWN 28 2010 Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 903 Andean Goose Way Prince Georges Upper Marlboro 8. Date of Birth (Month, Day, Oct. 24 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1 ₩ 2 □ F 1960 Washington, DC 50 578-90-5134 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director Upper Marlboro MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20774 903 Andean Goose Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Specify: Black 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 XNo ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Postal Carrier U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Shirley Whitlock John Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any injury or other trau 903 Andean Goose Way, Upper Marlboro, MD20774 Pamela L. Brown/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) National Cemetery 11/12/10 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Factore Funeral Home Bru 814 Franklin St., Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) iabetes **Physician** year /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural

death certificate be executed and P.O. Box 68760, physician attending signed by the a Id be detached f Division or Vital Records, peen certificate this funeral ne Hospital or Attending Pl n 24 hours after death. After t

72 hours after

filed withi Hygiene.

Baltimore, Maryland 21215-0036

5 Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To th. within 2. Registrar

31. Date filed (Month, Day, Year)

Signatule and title of certifier

30. Name and address of person who completed cause of death (Item

(Check only one)

Swann

and manner stated.

NOV 0 3 2010

filled in by

Medical

29c. License number

D0067634

ccard Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Nov. 1, 2010 12:00PM Physician/ Jack Arthur Bauer 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Rockville National Lutheran Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | A D 1 - 2 3 , 1 9 3 7 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number Nebraska **Funeral** 1 XM 2 - F 506-42-1500 73 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 Yes 2 No Rockville Montgomery Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20850 Funeral 9701-Veirs Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. 1 1 Never Married 2 Married 2 1 Yes X No Specify. Specify: White Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced 1970 Completed 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Religion Clergy 4 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Evelyn Davidson Urlich Bauer ൧ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md. 20601 10478 Hull Ct., Waldorf, Keith Bauer - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition ematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Littlefield, Texas ittlefield Mem.Pk.11/6/2010 22. Name and Address of Facility 2222-Wisconsin Ave., NW . Signature of Funeral Service Licensee Hysong Weller hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final EMENTIA HEI hER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner PREUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month in the past 12 months? 2 No ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown P.O. 1 s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown by Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s performed' has 2 🗷 N certificate 26. Place of Death (Check only one) Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifine 25. Was case referred to medical neral Director: After this certific filled in by the funeral director, Be Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ဂ္ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 🗷 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hot To the Fune completed fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 2010 NOVEMBER 1)00 51158 Muly D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20810 ROCKVILLE DETRIS 9701 VATR MA 32. Registra 's Signa 31. Date filed (Month, Day, Year) State NOV 0 3 2010 Registrar

			For State	State of Marylar				Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of l	Death		Reg. No.	0 (3604
	Physici			P. Bryson				2. Date of De Octobe:)1 ^{Vgar}	3. Time of Death
	Medi Exami		4a. Facility Name (if not institution, give stree	t and number)		4b. City Town o	r Location of Death		4c. Count		10:00 PM
			Ardens Court	s			ver Spri			ntgon	nery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th Voorl	9. Birthp	lace (State or Foreign
	Director	4	409-12-8076 Usual Residence of Decedent	96	Yrs.		Tiodio Willi.	Aug. 1	Z, Year 1914	Ie	nnessee
	land show dat	호	10a. State 10b. County	10c. City	y, Town or Loc	ation				10	Od. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Montgomer	у		Si	llver Spr	ing			1 🎛 Yes 2 □ No
	th the	E	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
	ath wi	Funeral Director	2505 Musgrove Road				20904		Unite	ed Sta	ates
ယ	er dea or ite	by Fi		Vas Decedent Ever in U.S Armed Forces? Yes 2 X No		as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
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12	ithin 7 ene. than he M	l e		ollege (1-4 or 5+)	life. DO	NOT use retired)	uring most of work	ang			•
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/lan	d be fi dental irked tic ev	유		Parker			18. Mother's Nam	Mollie		9)	
Maryland 21215-0036	should and h is ma		19a. Informant's Name/Relationship (Type, Pr		19b. Mailing	Address (Street a	nd Number or Rura			tate Zin Co	nde)
≥ (1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mark S. Jimerson -	Nephew	1702	Golf Cou	ırse Driv	e Mitc	hellvill	Le, Mo	20721
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Remo	val from State 20b. Pla	ace of Disposi metery, crema	ion (Name of tory or other place		Date mber 5,	20c. Location -	City or Tow	n, State
Ē	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee		Fort Li	ncoln	2010	1			Maryland
Ba	permit. Departr Importa any inju		1. Kund	Louis	4	001 Benn:	^{s of Facility} Ste ing Road	NE Was	hington	ome,	Inc. 20019
			23a. Part . Inter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death, se on each line.	Do not enter	he mode of dying	, such as cardiac o	or respiratory arre	est,		Approximate
F	h sician/		Immediate Cause (Final disease or condition	End Stage R	enal D	isease					nterval Between Inset and Death Years
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	e exection are	<u>@</u>	resulting in death) Last	Due to (or as a conseque	nce of);						
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Вох	death certif ne attending ed for use a	by Physician/N	in the past 12 months?	Live Birth 2 Fetal of Pregnant at time of dea	death 3 🔲 E	ctopic pregnancy ther (specify)			23d. Date Mon	of delivery	av Year
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rds	been si should	eted						1 □ Y€	es 2 🖾 No 3	B 🗆 Probab	oly 4 🗆 Unknown
) (၁)	has b	Completed						24a. Was ar autops	v I pr	ere autopsy ior to comp	findings available letion of cause of
E E	certificate harector, page		5. Was case referred to medical					perform 1 Tyes 2	ned? de	ath?	
Vita	nis cert direct	To Be	examiner? 1 Yes 2 No Hospita	: 1 Inpatient 2 EF	VO. t 1 - 1		e of Death (Check			As	sisted
Division of Vital Records, P.O.	h. After thi funeral				Bb. Time of	28c. Injury a	4 Nursing Hon		nce 6 X Other v injury occurred		Living
ion	leath. tor: Af the fu	i ca	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Monal, Day, Teal)	injury	M 1 ☐ Ye	s 2 🗆 No		,,		
.≥ ≥	after deat Director:	Certificate:	4 Homicide determined 28e	Place of Injury - At home building, etc. (Specify)	, farm, street,	factory, office	2	8f. Location (Street) City or Town,	eet and Number	or Rural Ro	ute Number,
Di	24 hours Funeral eted filled	- Sa	9a. Certifier 1 X Certifying Physician T	the best of my knowled	go doeth oos	ward and also a street 1			,		
he Ho	within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	1	the basis of examination ar oner: To the best of my kr	nd/or investigat nowledge, deatl	red at the time, do on, in my opinion, noccurred at the ti	ate and place, and death occurred at t me. date and place	due to the caus he time, date and and due to the c	e(s) and manner of place, and due to ause(s) and mann	as stated. o the cause(s) and manner stated.
Į.	within 2 To the I complet	2	9b. Signature and title of certifier			29c. License nu			d. Date signed (/		
			- Junior			1	3287	0	ctober 2	28, 20	010
JL.	_5	1	D. Name and address of person who complete Paul Armstrong, M.D.	cause of death (Item 23			te 102	Laurel,	Md. 20	707	
	State Registrar	3	NOV 0 2 2010	32. Registar's Signature							

David Baker	1	1- For State	St	ate of Maryl	and / D	epartment Certificate	of I	Health and Death	d Me	ental Hy	ygiene	Reg. N	o. 2010 –	360	42
Physici	an/	1. Decedent's Name	(First, Middl	e,Last)							2. Date of D	eath Day	/ Year		3. Time of Death
Medical Exam	iner	David									Novemb	er 8, 2	2010		0720 hrs
<u> </u>		4a. Facility Name (if		n, give street and n	umber)			City, Town, or I	Locatio	on of Death		ľ	4c. County of Frederick	Death	
		7143 Lingan		6. Sex	7 Ago /Ir	n yrs. last birthday)		If Under 1 Year	- I If I to	nder 24Hrs	8 Date of	Birth/MI		9. Birth	place (State or
Funeral Director		5. Social Security Nu					- 1	Months Days	\rightarrow		7		F	oreign	
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any		Usual Residence of 10a, State 1	Ob. County		100	c. City, Town or Lo	Town or Location							T	10d. Inside City Limits
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arylar 8a-f s	Director	10e. Street and Num	ber				1	10f. Zip Code				10g. C	itizen of What	Count	ry?
the M n or 2 tiffed	Dire	7143 Lin	eanore	Road				21701				Uni	ted St	ate	5
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status		12. Was De				Decedent of Hisp , specify Cuban,				No-	14. Race White,		an Indian, Black,
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rall,	ģ	3 Widowed		orced If Yes, Give Ye or Dates:		1		es 2 No Usual Occupati	speci.	-	and Hann	lich	Specify: Kind of Busin	Whi	
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5-0036 High within 7 Hygiene. tother than	Con	17. Father's Name (F	irst, Middle,	Last)				1	1B.Moth	ner's Name	(First, Middle	e, Maide	n Surname)		-
215 be file ntal H riked c	Be (James Ru	sse11	Baker Sr.					Sus	anna	Schmid	lt _			
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MD d 2 sho lth and n 27 is		Susanna		Mother				inganor		d. F	rederi		Md. 2		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo		3 Removal f	rom State	20b. Place of Disp crematory or	other	n (Name or cerr place)	netery,		Date	200	. Location - C	ity or i	own, state
Page Page nent c		4 Donation 5				Mt. 01i					13-201	0 1	Frederi	ck,	Md.
Balti Permit. Departm Imports		21. Signature of Fun				22	. Nan K	ne and Address eeney & 06 E. C	of Faci Ba	sfo <u>r</u> d	Funer	al.	Home		1701
	-	Jacque L11 23a, Part I. Enter the		ceh per di		death Do not ente	1 er the	06 E. C	hur such as	ch St s cardiac or	respiratory	ieri	hock, or heart	· Z	Approximate Interval
Physician /Medical Examiner		failure. List only Immediate Cause (F or condition resulting	one cause inal disease	on each line. a. Complicati Due to (or as	ons of c	hronic alcohol									Between Onset and Death
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ires that the signed by the detach	à	Part II. Other signifi	cant condit	ons contributing t	o death bu	t not resulting in th	e und	lerlying cause gi	iven in	Part I.					e cause of death? bly 4 Unknown
Division of Vital Records, P.O tal or Attending Physician: The law requires that the start death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed										pe 1 ⊻ Ye	opsy formed	prio dea		psy findings available mpletion of cause of 2 No
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f Vid Physic er this ral dir	မ	1 ✓ Yes 2 27. Manner of Death		28a. Date		2 ER/Outpatie		0011	٠.				njury occurred		ocene
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isior Attend r death rector: by the	Certification	2 Accident	Inves	stigation 28e Plac	ce of Injury	- At home, farm, st	treet,	factory, office bu	uilding,	etc.	28f. Location	(Street	and Number	or Rura	I Route Number, City
DIVI pital or ours afte	ertif	3 Suicide 4 Homicide		mined (Specify))						or Town	, State)			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical C	29a. Certifier 1	Certifying Pl	nysician: To the be miner:On the basis	st of my kn	owledge, death oc	curre	d at the time, dat	te and i	place, and occurred at	due to the ca	iuse(s) a	and manner as place, and due	s stated	i. cause(s)
To tl withi To tl	Medi	29b. Signature and ti		and manner				29c. License			50		I. Date signed		
	-			. 1/		\		O.C.N			ME		vember 9,		
		30. Name and address Theodore M.				(Item 23a) ical Examiner	90			Street Ra	altimore M				
	e te	31. Date filed (Month			gistrar's S										
Regis		M	AR 1 4			. A. A.	au	Les "							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 3:17P Blake October <u>Dorothea</u> R. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills Prince Georges 6706 Robinia Road If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours **Director** 14 579-56-5245 194 Wash 67 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Temple Hills MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 20748 6706 Robinia Road <u> United States</u> within 72 hours after death Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🙀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ρ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed 3 ₩ Widowed 4 □ Divorced and Mental Hygiene.
is marked other than "natul raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Government permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tt</u> once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jackson Roberta Elmer Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6706 Robinia Road
Temple Hills MD

20b. Place of Disposition (Name of cemetery, crematory or other place) Hill/daughter Lisa 20748 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 11/5/10 4 ☐ Donation 5 ☐ Other (Specify) <u>Harmony Memorial</u> Landover, MD 21. Signatur of uneral Service License 22. Name and Address of Facility Hodges & Edwards F.H. Suitland, MD. 20746 Hill Rd., Silver Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Retween Immediate Cause (Final Enysician. Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death ed by the a q ☐ Unknown g Unknown Division of Vital Records, P.O. completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 🗌 Yes 2 🗌 No s after death Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 11-04-2010 D0070102 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) #200, Largo, 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State **対例V 17** Registrar

O DHMH 17 Rev 7/2009

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ MARY LOUISE BUTLER Novembe 201C Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charle Plata 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 M 2 X F Months Days Hours Min. (Month, Day, Year) 19 MD Country) 218-30-3580 91 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD. CHARLES POMFRET 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7520 MARSHALL CORNER ROAD 20675 items 23a U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Was Decedent Armed Forces?

1 Yes 2 No than "natural", or 1 Never Married 2 Married þ AMERICAN INDIAN If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Baltimore, Maryland 21215-16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 9th Page 1 and 2 should be filed with ment of Health and Mental Hygier ant: If item 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH P. HARLEY MARY A. THOMPSON traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh De partment of Health ar Important: If item 27 is any injury or other trau POMFRET, MD. 5370 HARLEY'S PL. JAMES W.HARLEY, SR.-SON 20675 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ST. JOSEPH S CEM. 11-13-10 POMFRET, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licens **M00479** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition nset and D ath Physician/ Medical resulting in death) as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No Yes 2 the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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Registrar

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completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HAZEL T. BUTLER 25 11:00PM OCTOBER 2010 4c. County of Death P . G . 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CRESCENT CITIES CENTER RIVERDALE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, DEC 5, 9. Birthplace (State or Foreign Country)
S.C. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 □ M 2 X F 248 30 2281 89 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10h County 10a. State 1X Yes 2 No WASHINGTON D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20002 OUINCY PLACE N.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 XNo Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC PUBLIC SCHOOLS COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOUISE SPANN MERCHANT WILLIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1520 NEAL ST., N.E. WASH. D.C. 20002 DEBORAH DIXON/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition MARYLAND NAT. CEM. 11/5/10 1 XBurial 2 Cremation 3 Removal from State LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 20010-21. Signature Funeral Service Licensee 22. Name and Address of Facility WATSON F H 3435 14th ST., N.W. WASH. DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Kidney Disease Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Deep van Th Rombosis Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Pitritary Adenoma Retroperitoreal Hematoms 1 ☐Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examination and Informatic and Informatical Annual Annua

3altimore, Maryland 21215-0036

Box 68760,

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Records,

Division of Vital

requires that the death certificate be

Examiner Physician/Medical Š Completed

Be

Certification: To

Medical

burial-transl attending physician for use as the burial the ed by the detached f s been signed be should be deta cate has t page 2 s certificate funeral director, After this

IF FFMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown

1. Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Working

5 Pending

investigation

6 Could not be determined

101852

29d. Date signed (Month, Day, Year) October 26 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DEVOREMD4203 Queensbury Rol Hyaltsville MD 20781 31. Date filed (Month, Day, Year)

State Registrar

OCT 2 9 2010

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0/22/2010 12:40 aum Physician/ Joseph W. Ciarrocchi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min 5/26/44 Year) Country) 1 **XX**M 2 □ F 578-74-7921 CA 66 Director Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 🎞 No Columbia Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral USA 21044 10804 Terrier Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, et-1 Never Married 2XXMarried à White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lina Caranfa Louis Ciarrocchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21044 10804 Terrier Ct. Wife Anna Marie Ciarrocchi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Peremation 3 Removal from State 10/31/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 77 Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: Dice မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certif 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Suite 4105, Baltimore, ND 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ Mariette Jeanine Carione 2010 12:18 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Edgewater 214 Maryland Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 M 2 F *\$7237*4930 Maine 006-24-4495 80 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyaminar must have also any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10b. County Director Anne Arundel Edgewater Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 214 Maryland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice Paradis Charles E. Gallant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Maryland Avenue, Edgewater, MD 21037 Mariette Bissett - Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date Baltimore Crematory 10/26/2010 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility John M. Taylor Funeral Home Miglin Mother 147 Duke of Gloucester St. Annapolis. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Luc to (or to a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Vear Month Day Pregnant at time of death the page 2 should be detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an onary has autopsy mertenson certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No he Hospital or Attending Physician: 111e in 24 hours after death.
The Funeral Director: After this certificate nipleted filled in by the funeral director, pa 25. Was se referred to medical To Be 26. Place of Death (Check only one) 2 No examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hosp within 24 hou To the Fune completed fi

Carol Pressey 3168 Braverton St., #250 Edgewater, Maryland 31. Date filed (Month, Day, Year) 0 CT 2 6 2010 32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

State Registrar only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and on investigation, in my opinion, and other cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number DO25134 29d. Date signed (Month, Day, Year)

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			State Registrar		Ce	rtificate of De			giene Reg. No. ?	010	2601.0					
	Physicia	an/	1. Decedent's Name (First, Midd Jose Raul Cerra					2. Date of Dea	ath	Year	3. Time of Death					
-	Medi Exami		4a. Facility Name (if not institutio	n, give street and number)		4b. City, Town, or Loc	cation of Death	October	$\overline{}$	Inty of Death	5:30 a M					
			Holy Cross Hospi			Silver S	Spring			pomery						
	Funeral Director		5. Social Security Number 578–78–1778 Usual Residence of Decedent	6. Sex 1 № M 2 □ F	ge (In yrs. last birthday) 54 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 3,	9. Birthplace (State or Forei County) 1955 Nicaragua							
Maryland	28a-f show	Director	10a. State 10b. County	ontgomery	10c. City, Town or Lo				10	Od. Inside City Limits						
th with the	ns 23a or must be n	Funeral D	10e. Street and Number 3632 Gleneagles D			10f. Zip Code 20906			10g. Citizen o	try?						
036 rs after dea	Department of the tauth and Mental Hygiene. Process are used in with the Maryland Department of the tauth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 🕱 Ma 3 ☐ Widowed 4 ☐ Divorced	If Van Civa	No.	Was Decedent of Hispa If Yes, specify Cuban, № 1 🗷 Yes 2 🗌 No S	/lexican, Puerto R	lican, etc.)	В	Race - America Black, White, e Bify: White	9. Birthplace (State or Foreign Countries and Death 10d. Inside City Limits 1 Yes 2 No Inat Country? - American Indian, (White, etc. White siness Industry - Approximate Interval Between Onset and Death Onset and Death of delivery h Day Year - Probably 4 Vunknown - Probably 4 Unknown - Probably 4 Unknown - Probably 4 Unknown - Probably 4 Unknown - Probably 4 Unknown					
Maryland 21215-0036	ene. • than "natu he Medical	Completed		nt's Education est grade completed) College (1-4 or	16a. Dece (Give life. D	dent's Usual Occupation kind of work done durin O NOT use retired)	n ng most of working		16b. Kind of	f Business Ind						
rland 2	Aental Hygi Irked other tic event, t	To Be	17. Father's Name (First, Middle, Jose Raul Cerrat	Last)			signer . Mother's Name . ria Asunci	ASA nme)								
e, Mary	Health and Me Hm 27 is mark her traumation		19a. Informant's Name/Relations Aura N. Bihun/S		19b. Mailir 12742	ng Address (Street and I	Number or Rural I Drive, Sa:	Route Number, int Thama	City or Town	, State, Zip Co . 7252	ode)					
Baltimore,	intment of H ortant: If ite njury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	Specify)	Gate of H	natory or other place) eaven Cemeter	y Nov. 2010		Silver	,	,					
Ba	Depar Impor any ir	IJ	21. Signature of Funeral Service I	Licensee	5	Francis of 00 University	offins Fur Blvd. W.,	neral Hom Silver	e Inc. Spring,	MD 2090	01					
<i>)</i> + 1	ysiciam Medical xaminer	er	23a. Part 1. Exter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Failure Due to (or as b.	the death. Do not enter. To Thrive a consequence of: ic Gastric Ca		ich as cardiac or i	respiratory arre	st,		Interval Between					
8760 ificate be executed	hysician and he burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	a consequence of):											
). Box 687 the death certifica	To the Funeral Director. After this certificate has been signed by the attending physician and properties of the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 _	Ectopic pregnancy Other (specify)				Date of delivery						
rds, P.O.	en signed k ould be det	þ	Part II. Other significant condition	ens contributing to death b	ut not resulting in the ur	nderlying cause given in	Part I.									
VITAI KECOLOS, ysician: The law requires	ficate has be or, page 2 sh	Completed	25. Was case referred to medical					24a. Was an autops perform 1 Yes 2	y ned?	prior to comp death?	oletion of cause of					
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VISION OF	or: After the funeral	Certificate:	27. Manner of Death 1	28a. Date of injur (Month, Day	y 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes	280	d. Describe how								
DIVIS	eral Direct		4 Homicide determi	ned 28e. Place of Inju building, etc				f. Location (Stre City or Town,	State)		oute Number,					
the Hosp	o the Fundament	Med	(Check Z Medical E	Physician: To the best of a kaminer: On the basis of ex Nurse Practioner: To the b	amination and/or investi-	gation, in my opinion, dea eath occurred at the time	ath occurred at the , date and place, a	e time, date and and due to the c	place, and du ause(s) and m	ue to the cause nanner as state	d.					
	54		> Blut	ND.		29c. License num	D68096		_	ed (Month, Day 29, 201	. ,					
		3	30. Name and ddress of person was Satyam A. Shah, ME			•	D 20910									
	State Registra		11. Date filed (Month, Day, Year) WOV 012	2. Registra	's Signature											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $2\overset{\text{Day}}{1}$ Month 10 Physician/ 2010^a 9:30a Lucia Canter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Rid</u>erwood Village Silver Spring Montgomery 9. Birthplace (State or Foreign Country)
Cuba If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Min. 1 □ M 2 **X** F Hours 11 Nonth, Bay, Year 1911 98 Director 577-40-9903 Usual Residence of Decedent show 10d. Inside City Limits of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Columbia Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21044 5426 Hickory Overlook Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Specify: White If Yes, Give 3 🕅 Widowed 4 🗌 Divorced Cuban Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Administrative Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Elizabeth M. Ross John M. Willingham Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5426 Hickory Overlook Columbia, MD 21044 Jacqueline Derr/ Daughter in Law 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō Ft. Lincoln Crematory 10/30/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service Line 22. Name and Address of FacilityFt. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part #. Entertine disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Chronic Kidney Disease, Stage III disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate rause. Find Indonying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 💹 No Month Year Day Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 🗌 Yes 2 X No 3 □ Probably 4 □ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, æ 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 111263 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n 20 MD 3110 Gracefield Rd. Silver Spring, MD 20904 Harding, 31. Date filed (Month, Day, Ye NOV 0 2 2010 State Registrar

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	Physicia Medic				Shirley		Cha	dwick	$\overline{}$				Month Ioveml			2010		8 P M
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	Funeral Director		5. Social Security N 215-34-0	umber 6	6. Sex 1 ☐ M 2 🏋 F	7. Age		st birthday) Yrs.		der 1 Year	If Under 24 H		Date of Bi (Month, D une 5	rth ay, Year	937		hplace (Sta intry) ary1a:	ite or Foreign
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Fur	11. Marital Status		12. Was De Armed I	Forces?		13.	Was Dec	edent of H ecify Cuba	ispanic Origin? (an, Mexican, Pue	Specify erto Rica	Yes or No an, etc.)	ļ.a		ce - Amer	rican Indian	1,
Baltimore, Maryland 21215-0036	s after al", o Exam	d by	1 ☐ Never Marr 3 ☐ Widowed		d 1 ∐ Ye If Yes, 0 Year or		10		1 🗌 Yes	2 ሺ No	Specify:				Specify	∕: Wh	ite	
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	Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List oni Final	y one cause on a	each line.	VIC	0351			g, such as cardi	124			SE		Approxi Interval Onset a	mate Between nd Death
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. Box 68760	or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		e Birth 2	☐ Fetal	death 3	Ectopi Other	c pregnanc (specify)	Sy					ate of deli onth	very Day	Year
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Division of Vital Records,	sician: The law re certificate has be irector, page 2 sh	Completed by										-	24a. Was auto perfi 1 Yes	opsy ormed?		prior to death?	opsy findin ompletion 2 No	gs available of cause of
ita	sician: certifi rector,	Be	25. Was case referrence examiner? 1 Yes 2	ed to medical	Hospital:					Othe	ace of Death (Ch					_		
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ivisio	il or Attendi after death. Director: A d in by the fu	Certificate:	3 Suicide 4 Homicide	6 Could no determine	t be 28e. Plac	ce of Injury ding, etc.	y - At hor (Specify)	me, farm, str				28f.	Location (City or To			er or Run	al Route No	umber,
	To the Hospital or A within 24 hours after to the Funeral Dire completed filled in b	Medical	(Check 2	Certifying P Medical Exa	miner: On the b	asis of exa	amination	and/or inves	tigation, i	n my opinic	on, death occurre	d at the	time, date	and plac	e, and du	ie to the c	ause(s) and	manner state
	To the within To the comp	2	29b. Signature and	A 1	I I	1. TO THE D	UST OF THY	Kilowieuge,		9c. License		piace, a	nd dde to t				, Day, Year)	
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			30. Name and address	ess of person wh	o completed car	use of dea	ath (Item	23a) (Type, F	,	STREE	T. KISI	NG	SVI	V.	MI) 6	21911	
	Stat Registra		31. Date filed (Monti		$\begin{array}{c c} & & & 32 \\ \hline & & & 2 \end{array}$	Registrar	s Signatu			<u> </u>	,,,,,,,,	, , , ,	<u> </u>	- 1	10.4			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 7:20 a M 2010 Dorothy Chandler November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Medica Center 0 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Year) Director 408-36-5747 89 7 192 TN Usual Residence of Decedent 28a-f shov 10a. State 10b. County or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Charles Waldorf ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2005 Saint Thomas Drive #410 20602 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-003 Specify: than "natural", Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Chemist <u>Walter Reed</u> is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I မ Williams Harvey Gladys Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 4602 Hallowan Court
Upper Marlboro, MD.

20b. Place of Disposition (Name of cemetery, crematory or other place)

11/17 James Chandler III/son 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State :11/17/10 4 Donation 5 Other (Specify) verdale Park Crematory Riverdale, MD 22. Name and Address of Facility Hodges & Edwards F.H. . Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Pan 1. Enter the disease, or complications that vauges shock or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HENO CORNIZE Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ysician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No certificate Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Hospital: 1 Yes မ R/Outpatient 3 DOA 1 🗌 Inpatient 2 🖟 this Director; After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Cortificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 X Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only o Certifying Nurse Phacticker: To the pest of dat the time, date and place, and dee to th the 29b. Signaty d title of certifier cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 8:00 a M NOVEMBER 11 2010 ISAAC HENRY COVEY, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent Galena 14021 Gregg Neck Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Sept 17 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral Days Hours Months 1914 Maryland 1 ▼ M 2 □ F 96 219-14-3248 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Kent Galena Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 14021 Gregg Neck Rd. 21635 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ₩ Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Motor Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Frampton William Henry Covey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any Injury or other trau Galena, MD. 21635 14021 Gregg Neck Rd. (daughter) <u>Betty Jean Henry</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Still Pond Cemetery 20c. Location - City or Town, State Pages ' Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify), 11/15/10 Still Pond, MD. nsee Furer Service Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 Approximate Interval Between Onset and Death e disease, or complications that caused the de i.h. Do not enter the mode of failure. List only one in use of each line. of dying, such as car lac or respiratory arrest, Immediate Cau (Final disease or condition resulting in leath) lars **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical requires that the death certificate the attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

31. Date filed (Month, Day, Year) 河通识

29b. Signature and title of certifier

29a. Certifier

(Check only one)

6602 Church Hill Rd. Chestertown, MD. Wayne D. Benjamin, M.D. 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Nonth, Day, Year)

21620

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Oct ober 19:58 PM **Physician** Richard Creutzburg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Baynew Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Delaware April 18, 1941 69 221-26-3613 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dired Examiner must be notified at 1 ☐ Yes 2 X No Director New Castle Delaware Wilmington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 200 Tyrone Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: 3 ☐ Widowed 4 🏋 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natu Elementary/Secondary (0-12) College (1-4or 5+) Painting Contractor Painting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill shi of Health and Mental Hyt: If Item 27 Is marked and Be Herbert Creutzburg Ida Hartwig 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dave L. Creutzburg/Son 1918 Windermere Avenue, Wilmington, DE 19804 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ament of He 20a. Method of Disposition October 0 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or Family Cremation Services 14, 2010 Wilmington, DE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiac Arrest Immediate Cause (Final HOUV **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HOW pivation Examiner Termino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consection ce off Examiner the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 √Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 autopsy 2 ☑No 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 2 ☑ ER/Outpatient 1 ☐ Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t After 1 Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12,2010 D0067067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shaver by a 4940 Eastern Avenue, Baltimor Eastern Avenue, Baltimore, MD Shavor Bord 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Registrar 1. Decedent's Name (First, Midd	tle Last)	- Ceru	ilcate of	Death			2. Date of D			3. Tir	ne of Death
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Ignature of Funeral Service	Li Inseq					•	575 1 Ale	5 (Cas exand	tlewell ria, V	an Dr: Virgin	ive nia 22315
Physician /Medical	23 art I. Enter the disease, of failure. List only one cause	r complications that cause on each line.	sed the death. D	o not enter th	e mode of d	ying, such a	s cardiac o	respiratory a	arrest, sho	ock, or heart	App	roximate Interval ween Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)				-						-	Deadi
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funcat Director: After this certificate has been signed by the attending physicia completely filled in by the funcat director, page 2 should be detached for use as the buria

Physician/Med

2

Completed

Be

101

Medical Certification:

State Registrar

Tine a-b, PII,27, per ME g910 12.27.10 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 🗸 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Multiple sclerosis; Hypertensive 24a Was an 24b. Were autopsy findings available atheroscleortic cardiovascular disease prior to completion of cause of autopsy performed? death? ✔ Yes 2 No 1 Yes Obstructive hydronephrosis 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 6, 2010

31. Date filed (Month, Day Year) OCME

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Donna M. Vincenti, MD

and manner stated.

Assistant Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible has Engure/All Copies Are Legible.

Amend I tems State of Maryland 4 Department of Health and Mental Hygiene

amend #5 Per FH 6913 3/10/2011 JH For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 904 bei 800M BERTHA H. CASH Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany Social Security Number 7034 213–24–7024 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** (Month, Day, Yea 01/01/192 Country)
West Virginia 1 🗆 M 2 🗶 I Months Days Hours Min Director 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Me fical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD **Allegany** 1 ☐ Yes 2 🔀 No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16125 McMullen Highway 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **HOmemaker** Home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Franklin H. Mayhew Betsy Lee Houdersheldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16125 McMullen Highway, Cumberland MD 2 Deborah Whaley / Daughter 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date □ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Ebenezer Cemetery 10/08/2010 Augusta, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Upchurch, Funeral Home, P.A. Þ Cumberland, MD 202 Greene St., 21502 23a. P. 11. Enter the uplease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only on-cause on each light. Approximate Interval Between Immedia e Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi a that initiated events Due to (or as a consequence resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after ueau..

To the Funeral Director; After th 28a. Date of injury 27. Maymer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accid (Month, Day, Year) 5 Pending work?
1 \(\sum \) Yes 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print) Koad NL, /4. 31. Date filed (Month State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 5:10 NOV Cook 2010 Glenda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Western Maryland Hospital Center Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex Social Security Number **Funeral** Months Days 1 □ M 2 🗓 F 65 March 24,1945 220-76-4634 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ៦ Items 23a 17110 Reedy Parkway 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: "natural", or 1 ☐ Yes 2X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Martin William Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 S. Richardson Ave., Roswell, NM Brenda Gameson/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/4/2010 Smithsburg, MD Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due 16 or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 💢 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sigr ature and title of certifier DOE45031. 1500 Pennsylvania Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDDIQUI Hagerstown, MD 21742

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

NOV 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #21ate of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 201^{Yea} Charlotte Marie CHAMBERLAIN 9:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11019 Hopewell Road Hagerstown Washington If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** May II, 1 □ M 2 🛣 F Maryland 63 220-48-4967 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Washington 1 ☐ Yes 2X No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11019 Hopewell Road U.S.A. 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own business consultant 4 Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked of ည Clarence Oscar Smeak Helen should be Rohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 11019 Hopewell Road, Hagerstown, Maryland Martin Chamberlain - husband item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State November 1. 2010 Hagerstown, Maryland Hagerstown Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee Robert B. Rankin M00477 perDvx 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melignant Physician/ Motastatic week disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to for as a consequence of burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No signed by the a d be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 41866 November 1 1 mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | Kanan Hudhud, MD

46 B The mas Johnson Drive See 200 Frederick MO 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 Mary Curtis october Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** George's Prince Lanham Doctor's Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1 □ M 2 🕱 F 06/05/1931 79 219-54-7987 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show 10a State must be notified at Director Upper Marlboro Prince George's 1 X Yes 2 No MD 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20774 Funeral 11506 Bennington Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic Worker or other traumatic event, the 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Rosa Lee 2 Elliott Butler 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 1802 Longford Dr., Hyattsville, MD 20 19a. Informant's Name/Relationship (Type, Print) Ruth Arrington-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a.
Department of H.
Important: If iter
any injury or oth cemetery, crematory or other place)
Quantico Cemetary 1 X Burial 2 Cremation 3 Removal from State 11/2/2010 Triangle, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DL McLaughlin Funeral 21. Signature Juneral Service Lio see 20020 Wash. DC SE, 2019 MLK Jr. Ave. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate 28a. Part 1 Enter the disease shock, or heart failue. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (br as a consequence of) Examine Due signed by the attending physician and defeached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performe 1 Yes this certificate Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tyes 1 Inpatient 2 28d. Describe how injury occurred funeral . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Director: After 5 Pending Natural Accident 1 ☐ Yes 2 ☐ No М Investigation the 1 Suicide 6 Could not be 28f, Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title

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31. Date filed (Month, Day, Year)

OCT 2 9 2010

Roc

certifie

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Burns

8118 Good Lack Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 26, 2010 12:15 P M Curameng Faustina Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington Health & Rehab. Ctr. Ft. Washington Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year ine 10, 1 ☐ M 2 ☐XEX Months Days Hours Philippines 579-70-4193 918 Director June Usual Residence of Decedent shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2XXXIo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13012 Renfrew Circle 20744 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 1 Never Married 2 Married ☐ Yes 2 x xNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xx No Specify: Specify: Filipino 3 X Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher P.G. County Schools years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emilio Villanueva Tnes Floresca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13012 Renfrew Circle Ft. Washington, Maryland Mamie Curameng / Daughter-in-Law 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)
Trinity Mem. Gardens Cem. 10/30/2010 1XX Burial 2 Cremation 3 Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final ⊲Pπysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a ld be detached fi 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy 1 Yes 2 No 1 ☐ Yes 2X X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: မ 1 🗌 Yes 2 **X X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1XXNatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nucse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

CR

State Registrar 31. Date filed (Month, Day, Year)

7. 1 Auren no 1/701

32. Regitrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Civingsh Root For WKNington, inonylong

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 26, 2010 ear Bessie Dodd 8:10 amM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 31 Coachmans Road Anne Arundel Severna Park 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 212-26-0135 1 □ M 2 F Months Days Min. 02/19/09/19/34 Mary land 79 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2X No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 31 Coachman Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Service traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental H item 27 is marked of ဂ္ဂ James H. Nothey Rosemary Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby G. Dodd Spouse 31 Coachmans Road Severna Park,MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of I Important: If it any injury or of once. ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 10/27/2010 Glen Burnie, MD 21. Signature of Euperal Ser 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 al 23a. Part 1. Enter the cisease, or complications that caused shock, or heart failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final UNG Physician/ disease or condition resulting in death) Medical Examine DWG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician stached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ò Demanna 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 2 No Yes 2 X No 1 Yes To Be 25. Was case referred to medical director. 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) hours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F

State Registrar

29b. Signature and title of c

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ss of person who completed cause of death (Item 23a) (Type, Print)

OCT 282010

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BUTHUR

29d. Date signed (Month, Day, Year) 10,26,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36062 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M°D 0115 (J, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 2707 Summerview Way 7. Age (In yrs. last birthday) 92 yrs. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Michigan 371-07-1613 1 M 2 🗆 F Months Days Hours 1472971917 **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c, City, Town or Location Director 1 🗆 Yes 2 💆 No Anne Arundel Maryland 10e. Street and Numbe 10g. Citizen of What Country? United States 10f. Zip Code 21140 3027 Rock Drive Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White Completed Year or Dates. 1941-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the U.S. Government Revenue Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Margarete Muller Berthold Dorow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3027 Rock Drive, Riva, Maryland 21140 Linda MacWilliams/Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1.
Department of I
Important: If it
any injury or of ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2010 Altoona, Pennsylvania 4 Donation 5 Other (Specify) Calvary Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fy 2973 Solomons Island Road, Edgewater, MD 21037 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final HEART DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER - SQUAMOUS 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completed filled in by the funeral director, page 1 Yes 2 No ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

CH26H State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09:15 AM Shirley Elizabe 4a. Facility Name (if not institution, give street and number) Elizaba 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State of Foreign OCKVILL asev Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D Months Days Hours Min. (Month, Day, Yea Country) **Director** 237-70-9311 -19-Usual Residence of Decedent f show 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD Montgomer 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2091 7210 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 ₩Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lcc Edward Harriet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Davis anham 7014 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 W Burial 2 Cremation 3 Removal from State Chapel Cem. 11-05-2010 Incz 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee The House ct 22. Name and Address of Facility Williams MO1182 a 4804 Georgia Wash., DC ZCON Ave., NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Breast Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mijury that initiated events. Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Y Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy death?
1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Pother (Specify) 2 **N**No Hospital: 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: **M** Natural iniury 5 Pending Accident Investigation To the Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 29d. Date signed (Month, Day, Year) R143201

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Muneaster Mill

Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

. Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Nov 5, Physician/ 2010 DeMundo Frank James 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death New Hope Assisted Living Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) WV 1 □**X**M 2 □ F Min. Hours Dec 29 234-30-0546 Director 90 1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he norified at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 □**X**(es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Wempe Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Divorced 4 Divorced WW II Specify: white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retired Carman CSX Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert S. DeMundo Katherine (Gemma) DeMundo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 414 Wempe Drive Cumberland MD 21502 Thelma DeMundo wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bridgeport Cemetery 11/9/2010 WV Bridgeport 4 Domation 5 Other (Specify) Signatur of Funeral S vice Licensee 22. Name and Acdress of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Enysician** nas disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 2 1 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 DOther (Specify) Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed

NBA

7.M

GARY WACIONER

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17& 18 PER FH G911 1/10/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Оςу **Physician** Martha S. Devine NOV. 2010 3:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Emmitsburg
(In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | St. Catherine's Nursing Home Frederick 7. Age (III. 8. Date of Birth (Month, Day, 7 (ear)) 1920 9. Birthplace (State or Foreign **Funeral** 021-18-2730 Months Days Hours Min ^cMassachusetts 1 □ M 2 😿 F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at PA Franklin 1 Yes 2 No Director Chambersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2085 Wayne Rd. 17202 **USA** Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or iter 1 ∐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>Ş</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store 12 Owner/Operator 17. Father's Name (First, Middle, Last)
Shepherd
Melvin B. Shepard 18. Mother's Name (First, Middle, Maiden Surname) **D** Be ပ္ Elsie B. Burgess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca R. Ripka, Daughter 205 Windward Cove Court, Grasonville, MD 21638 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If ite any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | 11-6-2010 | Smithsburg, MD 21. Signature of Euneral Service License 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave., Smithsburg, MD 21783 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician 0 disease or condition resulting in death) arthe /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DSTAG Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Yea 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à icate has been si ; page 2 should t 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of autopsy performe death? certificate 2 No 1 ☐Yes 2 ☐No spital or Attending Physician: The hours after death.
neral Director: After this certificate y filled in by the funeral director, pag 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie -05-201C

State Registrar 31. Date filed (Month

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strar's Signature

Man

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Bec

			1 - State of Maryland / Dep Registrar Ce	artment of Health and N	Mental Hygiene Reg. No. 2010 36067						
	Dhusisis	/	1. Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death						
	Physicia Medio	al	DORIS R. DONEGAN		NOVEMBER 6, 2010 4:30 p M						
_)	Examin	er	4a. Facility Name (if not institution, give street and number) Laurelwood Care Center	4b. City, Town, or Location of Death Elkton	4c. County of Death Cecil						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign						
	Director		180-24-4739 1 □ M 2 🕱 F 79 Y/rs.	With Days Flours Will.	JAN. 17, 1931 Pennsylvania						
	and show	or	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits						
	Maryla 28a-f	rect	MD Cecil Elkton		1 ☐ Yes 2 🙀 No						
	h the Baor S	al Di	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
	ath wit	Funeral Director	96 N. Riverton Dr. 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21921 Was Decedent of Hispanic Origin? (Spe	U.S.A. ecity Yes or No-						
9	or ite		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.						
ဗ္ဗ	iurs af tural", al Exa	ted	3 X Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2🛣 No Specify:	Specify: White						
7	72 ho in "na Medic	Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired)	16b. Kind of Business Industry						
212	within giene. er tha		Elementary/Seconday (U-12) U College (1-4 or 5+)	emaker	Own Home						
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item Z7 is marked of ther than "ratural", or items 23a or 28a-f show either 27 is marked of ther than "ratural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Bert George	18. Mother's Nam Mary He	e (First, Middle, Maiden Surname) arb						
ير	ould but Me Me mark				al Route Number, City or Town, State, Zip Code)						
ž	id 2 sh salth a n 27 is er trau		I		na, MD. 21635						
				matory or other place)	Date 20c. Location - City or Town, State						
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) Kent Cre	emation Services 1							
Ba	Depa Impo any i		M00510	Galena Funeral Hom	e of Stephen L. Schaech Galena, MD. 21635						
			23a Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart fallure. List only one cause on each line.								
- 4	hysician.		Immediate Cause (Final disease or condition) emertia		Onset and Death Unknown						
	Medical Examiner		resulting in death) Due to (or as a consequence of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):								
	cuted and transit	dical Examiner	Cause (Disease or impury that initiated events C.		8						
	be exe sician a burial-	calE	resulting in death) Last Due to (or as a consequence of):								
3760	ficate b g physia as the b	/edi	d	•	73.						
× 68	h certi tendin r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy	23d. Date of delivery						
Box	e deat the ath	Physician/Me		Other (specify)	Month Day Year						
P.O.	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
S)	quires t	ed b		·	1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🗂 Unknown						
COL	aw rec las ber 2 sho	Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of						
Re	: The l cate h ; page				performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No						
<u>Ita</u>	sician certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Chec.	k only one) ome 5 Residence 6 Other (Specify)						
of o	ig Phy ter this neral d	te: To	27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how injury occurred						
<u>o</u>	tendir leath. tor: Af the fu	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No							
Division of Vital Records,	after of after of Direct of in by		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the within comp	5	29b. Signature and title of Certifier	29c. License number 0023322	29d. Date signed (Month, Day, Year)						
					7m MD 21921						
			S'. S SACHDEN MD 126 A, F.	thish of, Elk	(m 111) 21921						
	Sta Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, S. S. S. A. C. D. Ev. M.D. 126 A., E. 31. Date filed (Month, Day, Year) NOV 1 7 2010	Land							

3K DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2200 M Larry Lee Dill avember Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours Dec. 28, 1946 Maryland 63 **Director** 219-44-2530 Usual Residence of Decedent or 28a-f show a notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 963 Noland Drive 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Superintendent Asphalt Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ Irene Faulders Harold Marion Inez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 Jo Anne Dill - Wife 963 Noland Drive Hagerstown, Maryland permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park Nov.5,2010 Hagerstown, Maryland Signature of Funeral Osborne Peneraly Home, P.A. 425 S. Conococheague St. Williamsport, 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Colun Concer Year Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death s been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 2 0 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) lun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18cd Campus Hagerstown M.D. Michae Mac 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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	Examin			(If not institution, giv Winston		er)		4b. City, Tel	rown, or L			Md	4c. (
÷π	Funeral Director		5. Social Security 5 78 – 54 -	Number 6. 9	Sex 7. 1 □ M 2√2 F	Age (In yrs. I	as <i>t birthd</i> a Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D Nov . 1	av. Year)
-	Albert sens on room or		Usual Residence	of Decedent					- 1			1101.	0 / 12
	Maryland a-f show iffed at	tor	10a. State Md •	P • G •		10c. City Tem	ple	Hills		-			
	h with the 23a or 28 st be not	al Director	10e. Street and No. 5 4 0 5 W.	inston S	it.			10f. Zip 20	Code 748				10g. Citiz
	deat ms	Funeral	11. Marital Status		12. Was Decede	ent Ever in U.	S. 13	3. Was Deced If Yes, spec	ent of His	panic Orig	in? (Spec	ify Yes or N	0- 1
920	ours after ral", or ite Examine	by		rried 2 Married 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	[X No		1 ☐ Yes 2		Specify:	, Fuerio F	nican, etc.)	
9	72 hc natui lical	ted	(\$0)	15. Decedent's E	ducation		16a. Dec	cedent's Usua	Occupat	ion	of workin	a.	16b. Kir
2121	d within 7 giene. er than "r the Med	Completed	Elementary/Sec		College (1-4	or 5+)	Rec	ive kind of wor b. DO NOT us ceptic	nist	-	OI WOIKIII		Nati
ğ	al Hy othe	Be	17. Father's Name	e (First, Middle, Las	t)					8. Mother	r's Name	(First, Middle	e, Maiden
<u> a</u>	uld b Menta rrked	2	Richa	ard E. E	Brown					Mar	уС.	. Bro	wn
, Mar	and 2 sho alth and I 27 is ma er traums			Name/Relationship 1 H. Dav		band		ailing Address)5 Wir					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			sposition 2 ☐ Cremation 3 [5 ☐ Other (Spec		ate _ C	emetery, c	sposition (Namerematory or	ther place	; IN		ate 2,10	20c. Loc Cli
Balti	permit. Departn Importa any inju		21. Signature of F	Funeral Service Lice	Polins	ng		22. Name an Robin	d Address	of Facility	era]	L Home	e 13°
s, P.O. Box 68760,	sician: The law requires that the death certificate be executed was people as the burial-transit rector, page 2 should be detached for use as the burial-transit	by Physician/Medical Examiner	disease or condition resulting in death Sequentially list of any, leading to cause. Enter Uncause, Disease of that initiated even resulting in death. IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	conditions, immediate derlying or injury ts Last	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birt 4 Pregnar 9 Unknow	as a consequence of pregnant at time of don	uence of): uence of): ncy I death	3 Ectopic pr 5 Other (sp	egnancy ecify)				tobacco u
or o	equir sen s											1_	Yes 2
Division or Vital Records,	To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be do	Completed										24a. Wa auto per 1∐ Yes	s an opsy formed? 2 X No
ïta	stan: ertific ctor,	Be C	25. Was case reference	erred to medical						26. Place	of Death	(Check only	
>	nyslo	To E		No No	Hospital: 1 ☐ Inp	atient 2	ER/Outpat	tient 3 DO	A Other	4 □ Nui	rsing Hon	ne 5🏿 Res	sidence 6
0	ding Physician: n. After this certific funeral director,		27. Manner of De	ath 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time Injur	e of 2	8c. Injury Work	at ?	2	28d. Describe	how injur
iš	endin ath. or; A	atic	2 ☐ Accident	investigation				М		es 2∐l	No		
Divis	Hospital or Atter 24 hours after deat Funeral Director etely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not l determined	20e. Place o	f injury - At ho , etc. <i>(Specif</i> y	ome, farm,	street, factory	, office		2	8f. Location City or To	(Street an own, State
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funer.	Medical (29a. Certifier (Check only one)	1 X Certifying P 2 Medical Exa	hysician: To the baminer: On the bas and manne	is of examina	wledge, de tion and/or	eath occurred r investigation	at the tim , in my op	e, date an inion, dea	d place, a	and due to the	e cause(s) e, date and
_	To the within To the Comple	Me	29b. Signature ar	nd title of certifier				290	License		- 4		29d. Dat
				Winat.	c - L'				MD	3006	bΊ		Oct
			30. Name and ad	dress of person who	completed cause	of death (Item	23a) (Typ	oe, Print)					
CK	-10			netta C			800	Reser	vio	Ro	ad N	W Wa	sh
	Sta Regist		31. Date filed (Mo	9 2010	32. Reg	jist ar's Sign	ture						

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 26,2010 **Physician** Delores Anne Dawson 9:00P County of Death .G. Birthplace (State or Foreign Country) 941 Wash.,D.C. 10d. Inside City Limits 1 X Yes 2 ☐ No en of What Country? S.A. 14. Race - American Indian, Black, White, etc. Specify: Black nd of Business/Industry Cities ional League of Surname) r Town, State, Zip Code) 1s, Md. 20748 cation - City or Town, State nton, Md. 13 6th St. NW hington,DC20001 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year ise contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) y occurred d Number or Rural Route Number, and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year) t. 28, 2010 20007 D.C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Dorothy C. Egan Ĭő, 2010 2:51 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Country) Maryland 1 M 2 T Davs Hours 220-16-7846 85 **Director** Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified</u> at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39 Carriage Drive 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred J. Caron Estell McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Egan Jr. - Stepson 306 Halsey Road, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Mem. Gardens 10/19/10 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 1. Klober 147 Duke of Gloucester St, Annapolis MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Allure SolrAto Physician/ disease or condition resulting in death) Medical o (or as a consequence of): Examiner NEUMON) Sequentially list conditions, if any, bauing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine and -transit the Hospital or Attending Physician; The law requires that the death certificate be executed as a consequence of): nding physician ar Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

Yes 2 death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending thin 24 hours after death.

the Funeral Director: After impleted filled in by the fun 10/9/10 1 Yes 2 No 10:00A M tripped on step ladder & fell Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 39 Carriage Dr. Annapolis, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Cartifying Nurse Practioner: To the best of my knowl 29c. License number D0605 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed ONES 32. Registrar's Signature Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 3607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October . Oliver Junior Edwards 2:12 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham 8. Date of Birth Sept. 5, 1951 If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F Days Hours 577-70-9301 59 Cowryy Virginia **Director** Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles White Plains 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4210 Southwinds Place Apt. # 105 20695 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married ξ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Louis Edwards Sr. Ethel Poindexter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nichole Waters - Daughter 17112 Livingston Road Accokeek, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State November 2, □ Donation 5 □ Other (Specify)

ature of Funeral S vice Lice see Lee's Crematory Clinton, Maryland 22 Name and Address of Facility Stewart Funeral Home, Inc. Benning Road NE Washington, DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) <u>Seps</u>is Medical Due to (or as a consequence of): **Examiner** Cirrhosis of the Liver Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury <u>Kidney Failure</u> burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Hepatic Encephalopathy Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) __ in the past 12 months?

1 Yes 2 No Month 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 W 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Tes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident after death Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-29-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

G.

31. Date filed (Month, Day,

NOV 0 3 2010

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G00d

LANGHAM, M

10-08430 Jennifer Edwards

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 35072

		1- For State Registrar		Certificate of Death					Reg. No.				
Physici Medical Exami		Decedent's Name (First, Midd Jennifer	Lynn		Edward	S		2. Date of Dear Month November	th	3. Time of Death 0754 hrs			
		4a. Facility Name (if not institution 419 W. 1st Street	on, give street and nu	imber)	4	b. City, Town, o Cumberlan		eath	4c. County of Dea	ath			
Funeral Director		5. Social Security Number 213-27-2542	6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Day			th (MM/DD/YYYY) 9. E	Birthplace (State or Foreign Country) MD			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygione. ont: If item 27 is marked other than "natural", or items 23a or 28a-f show any rother traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 119 West Fir 11. Marital Status 1 Never Married 2 M	12. Was Dec Armed Fo 1 Ves or Cates: cify only highest grad	2 No	Cumberland 10f. Zip Code 21502 Int Ever in U.S. s? 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15b. Kind of Business/Indus								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle,		<u> </u>	Home	emaker	18.Mother's Na	ıme (First, Middle, M	Own Ho	me			
MD 21215-C nd 2 should be filed to shith and Mentai Hygi m 27 is marked oth.	To Be	Gregory Ec 19a. Informant's Name/Relations Katherine Ed	hip (Type, Print)	Mother	19b. Mailing	Address (Street) Owner Figure 1	Ka et and Number First Stre	therine (For Rural Route Num eet Cu	Hartsock) Ed nber, City or Town, Sta umberland	dwards te, Zip Code) MD 21502			
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition 1 Burial 2 Cermation 4 Donation 5 Other Sy 21 Signature of Funeral Service	pecify: Licensee	om State Sca		er place) eral Home	e, P.A.	11/10/201 al Home, PA	Гогозарт	own MD			
Physician VMedical Examiner		23a. Park / Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Methad	lone and	clonaz	e mode of dying,	Arginia Ava , such as cardia toxicat	ion	erland, MD 2150 est, shock, or heart	Approximate Interval Between Onset and Death			
ıted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	consequence of									
P.O. Box 68760, that the death certificate be executed sned by the attending physician and cleached for use as the burial - transit	51	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unk	AMENDED 23 a 23c. If yes, of 1 Live bit 4 Pregna	27,28a putcome of pregrirth ant at time of dealer	2 Feta	ME G90 al death 3 er (Specify)			23d. Date of delive Month	Day Year			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by PI	Part II. Other significant conditi		death but not re	sulting in the ur			1 Yes 24a. Was a autops perfor	an 24b. Were a prior to med? death?	obably 4 Unknown autopsy findings available occupletion of cause of			
ion of Vital tending Physician eath. or: After this certi	ation: To Be	Was case referred to medical examiner?	Hospital: 1 Ir 28a. Date of (Month,	of Injury Day,Year)	ER/Outpatient 28b. Time of Inj	3 DOA ury 28c. Inju	of Death (Che Other Nur ory at Work? Yes 2 No	rsing Home 5 1	Residence 6 🗹 Oth	er: Scene			
O se with the continued of the continued													
Fo the Ho within 24 Fo the Fu	Medical	(Check only		of examination ar					e(s) and manner as sta and place, and due to t				
	2		i, u	7		29c. Licens O.C.I			29d. Date signed (M November 5, 20				
		•	who completed causent Medical Exam		^{23a)} Penn Street	, Baltimore,	MD 21201						
St Regist	_	31. Date filed (Month, Day, Year)	2010 32. Re	gistrar's Signatui	e de Za	121							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G909 11/23/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ Vincent A. Falcone 2:15 October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 24 577-32-8+32 8. Date of Birth (Month, Day, Year) October 20, 1927 7. Age (In yrs. last birthday g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 83 Director Washington, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 100 Burgess Hill Way, Apt. #217 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes Give Specify: WWII White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Seconday (0-12) College (1-4 or 5+) Human Resource Supervisor Health and Human Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anthony Falcone Sophia Cileto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MaryBeth Minch / Daughter 4913 Camden Place North, Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Gate of Heaven Cemetery 11/1/2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Kogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumania disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last an Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be muter Vehicle 1 Yes 2 No 3 Probably 4 Unknown Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Flutter performed ×301 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 🗌 No Other: မှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death. October 12,2010 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) 1013 Wa 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signati D60417 11-1-2010

State Registrar

NOV 0 2

10 hisson

Thomas

Frederick

address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month) Physician/ GANNACONE 1811 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel West River 5102 Sudley Road Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 ØM 2 □ F Months Hours June 24 Director 401-62-9172 65 1945 Kentucky Usual Residence of Decedent I and 2 should be filed within 72 nows and 1 Health and Mental Hygiene.
If Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director West River Maryland Anne Arundel 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20778 5102 Sudley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes. Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City of Annapolis Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blair Lydia Gannacone, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5102 Sudley Road, West River, MD 20778 Linda D. Gannacone/Wife Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2010 Edgewater, Maryland uneral Service License 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home any ala 2973 Solomons Island Rd. Edgewater, MD 21037 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. 23a. Pag 1. Enter the disease, or complicati shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

AR

Name and address of person who completed cause of death (Item 23a) (Type, Prin

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:30 P Ethel Marie Green October 24 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21724 Garfield St. St. Mary's Great Mills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 M 2 X Days 220-16-7201 Months 84 0870971926 Mary Tand Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medi al Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Annapolis 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 **USA** 111 South Cherry Grove Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Ford Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 3√√√ No If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify. White Specify: 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene, Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Homemaker In Home 11 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Bowen Hazel Brooks 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is nany injury or at 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Marie Green / Daughter 47856 Molls Cove Ln. St. Inigoes, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 10/27/2010 Annapolis. Maryland 21. Signature of Function Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 2973 Solomons Island Rd. Edgewater, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition whine Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and I-transit resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 ☐ Yes 2 D No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 🐼 No AZZISTECLIVIU 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 6 Other 4 hours after death. uneral Director: After this ed filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) In 24 hours, or the Funeral Discompleted filler Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Jarboe MD James P. 24035 Three Notch Road Hollywood, Maryland 20636 Day, Year 31. Date filed (Mont

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mooth 1817 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Tate Hospice House Linthicum Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 M 2 □ F Days Min. Decth, Par Year 962 Marry land 220-84-1423 47 **Director** Usual Residence of Decedent 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits irector 1 ☐ Yes 2 🌠 No Maryland Anne Arundel Annapolis ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 920 President St. Apt A1 21403 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Completed **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72.1 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12th College (1-4 or 5+) Maintenance Watergate Apts any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Gross Martha Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 so of Health a item 27 i 920 President St. Apt Al Annapolis, Md.21403 Sarah Gross(Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of F Important: If ite 1 Burial 2 XCremation 3 Removal from State Metro Crematory 10-29-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname a Rose Sector Recility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 D. Rose MOOY83 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ STATE WIDEL disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 nding p nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2/ No HOSPICE 1 🗌 Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Division within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who completed gause of death (Item 23a) (Type, Print) EVENSE A WYANNAPOLIM D LIYO LHAE a CI 31. Date filed (Month, Day, Year) 0CT 2 8 2010 32. Reg strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 24 Physician/ 2010 October 2247 Eliza Greenleaf Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 27 Months Days Hours Year) 927 Maryland Director 217-24-2012 83 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1179 Summerfield Rd. 21054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1X Never Married 2 Married ☐ Yes 2 🔀 No 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th None None other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Greenleaf Eliza Carr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry W. Jennings (Nephew) 1412 King Haven Ct. Gambrills, Md. 21054 20b. Plet of Disposito (Val) e of 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State U.M. Church 10-28-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) WMane RARSeof Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown malnutribon. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical a B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl n 24 hours after death. e Fune al Director: After th 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pendina work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Nurse Practioner To the best of my knowledge of all originated at the time date and place and due to the cause(s) and maker as stated 29b. Signature and title of certifier BS8768953 Annapulis MD 21401 30. Name and address of person who cop of death (Item 23a) (Type, Print) 200

Registrar

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Saltimore,

Box 68760

Records,

Division of Vital

ΑA	30 Health		pt 10–29–10 K/ L State	AH	State o	f Marylan	d / Depa	artment of	Health	and M	lental Hyg	giene 20) 10	36078
1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death							Reg. No.		3. Time of Death					
Physician/ Robert A. Gonzalez					Month				Day Year					
q	Examiner 4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center					4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel				
	Funeral		5. Social Security Numb	per 6.	Sex	7. Age (In yrs. I		If Under 1 Yea Months Days	r If Unde	r 24 H <i>r</i> s. Min.	8. Date of Birth	1		nplace (State or Foreign ntryDistrict Columbia
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	and show	o		b. County			y, Town or Loc							10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD		Arundel	Į P	Annapol							1 🗌 Yes 2 🔀 No
	ith the 23a or at be n		10e. Street and Number		rother Mi	or t		10f. Zip Code				10g. Citizen of \		untry?
	ems 2	Funeral	1062 Litt	cie Mac	12. Was Dece	dent Ever in U.	S. 13. V	21409 Vas Decedent of	Hispanic O	nigin? (Spe	cify Yes or No-	USA 14. Rac		ican Indian,
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 Never Married 3 Widowed 4		Armed For 1 \sum Yes If Yes, Give Year or Da	2 🔀 No		f Yes, specify Cul			Rican, etc.)	Blac Specify	ck, White, Wh:	
15-(72 hou n "nat	nple		5. Decedent's only highest o	grade completed)		(Give I	lent's Usual Occi kind of work done O NOT use retire	dunna mo	st of workin	ng	16b. Kind of B	usiness Ir	ndustry
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Maryland	d Men marke	۲	Antonio				T			net J		Jones		
Ma	12 sho alth an 27 is r trau		19a. Informant's Name. Debra Gonz					ng Address (Stree Little				apolis,		
ore,	of Hear		20a. Method of Disposit		Demouslfrom	20b. F	Place of Dispo	sition (Name of natory or other pi			oer 25	20c. Location		
Baltimore,	:. Page tment tant: I jury o		1 Burial 2 💢 0 4 Donation 5 [Other (Spe	cify)	Otate	ro Cre	matory,	INC.		2010	Baltim		
Bal	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funda	al Service Lice	nsee		22 E	Name and Add Barranco 195 Ritc	ress of Faci & Sor nie Hy	ns, P	.A. Sev	erna Par erna Par	rk Fi	uneral Home MD 21146
	Physician/		23a. Part 1. Enterthe c shock, or heart fa Immediate Cause (Fina	ailure. List only			h. Do not ente	er the mode of dy	į					Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	(a. Due to (or as a conseq	uence of):		137	O > (e. u c e			Ngon
	d sit	niner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or iinju	tions, ediate	b. Due to (or as a conseq	uence of):							
	cate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last		c. Due to	or as a conseq	uence of):						1	
09	ate be ohysicii the bu	dica		•	d					<u> </u>			\rightarrow	4'
687	eath certifica attending p		IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, out	come of pregna	ancy					23d Da	ate of deli	iverv
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M	in the past 12 mor 1 Yes 2 N 9 Unknown	nths?		nant at time of		Ectopic pregna Other (specify)					onth	Day Year
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of V	y Phys er this eral dir	e: To	1 Yes 2 N 27. Manner of Death	10	28a. Date	npatient 2 of injury	28b. Time of	28c. Inj	4 ∟ <u>I</u> uryat			lence 6 Oth		fy)
on (ending sath. or: Afte he fun	ficat	2 Accident	Pending Investigat	ion	th, Day, Year)	injury		ork? □Yes 2[□ No				
Division	al or Att	l Certi	3 ∐ Suicide 6 4 ∏ Homicide	6 Could not determine	ے 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, str	eet, factory, offic	е		28f. Location (S City or Tow		er or Rur	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical Certificate:	(Check 2 🗌	Medical Exa	nysician: To the b miner: On the bas urse Practioner:	sis of examinatio	n and/or inves	tigation, in my opi	nion, death	occurred at	the time, date a	nd place, and du	ie to the c	ause(s) and manner stated.
	To the common of		29b. Signature and title	e of certifier				29c. Licer	nse number	A:	7	29d. Date signe	d (Month,	, Day, Year)
1	410		30. Name and address	of person wh	o completed caus	se of death (iten	n 23e) (Type, F	Print)		M	100	10	1	6 V
	Sta Registr		31. Date filed (Month, D	CT 26	2010 32. R	gistrar's Signa	ature 6. A	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per FD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 10/25/2010 5:30 A ANNELORE WILHELMINE KIRSCH GORE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **DORCHESTER** 304 ACADEMY ST., APT. 101 CAMBRIDGE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 X F 2/18/1927 **GÉRMANY** 217-38-5817 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or items 23a or 28a-f show traumatic event, the Medical Evantiner must be notified at 1¥Yes 2□No Director **CAMBRIDGE MARYLAND** DORCHESTER death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21613 USA 304 ACADEMY ST. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Medical Evanther and any Injury or other traumatic event, the Medical Evanther 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Ş 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **HEALTHCARE** LICENSED PRACTICAL NURSE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALLY NEUFUSS KARL KIRSCH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILLIAM E. GORE / HUSBAND 304 ACADEMY ST., APT. 101 CAMBRIDGE, MD 21613 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CAMBRIDGE, MD 10/29/2010 **GREENLAWN CEMETERY** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Arteriosclerone Cord'ovallular Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Dishetel Examiner BV11712 Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiclan Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ 10 After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST CAMPRIDGE MD 21613

DHMH 17 Rev 1/2001

State Registrar THANWY

31. Date filed (Month, Day, Year)

503 **4**32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Theodore William Gordon 2. Date of Death 3. Time of Death October 28. D2010 Physician/ 5:48 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthp... Country) PA **Funeral** Months Days Hours Min (Month, Day, Year) Feb. 19, 1958 219-76-6977 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director MD Gaithersburg Montgomery 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 20878 TISA 15 Oak Shade Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 25 Married "natural", or If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 1976-80 Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eve once. ൧ Gail Nacrelli William M. Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Oak Shade Road, Gaithersburg, MD 20878 19a, Informant's Name/Relationship (Type, Print)
Christy E. Gordon/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. Date cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 Cremation 3 Removal from State Alexandria, VA 4 Donation 5 Other (Specify) 2010 Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myocardial intarction minutes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner atherosclerotic coronar discase arten year 5 5 quentially list conditions if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 **No is certificate has director, page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director; / Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical conter Drive, 20850 Jonathan Wenk, MD Rockville, Mary land 31. Date filed (Month, Day, Year) State 01 2010

Registrar

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GORDON

TO DOKE

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2010 Rosa Mae Glover 3:03 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Prince George's Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2**X** F Director 267-34-8917 0/27/1926 Tarhee] Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State within 72 hours after death with the Maryland Director Capitol Heights 1 X Yes 2 ☐ No Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20743 U.S.A. 4605 Zion Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: and 2 should be filed within 72 hours aff Health and Mental Hygiene. tem 27 is marked other than "natural", other traumatic event, the Medical Exar 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Hot Shoppes Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Dessert Supervisor 3 vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hester King ၉ Ausby Riggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2209 Owens Road, Oxon Hill, Maryland 20745 Ella Glover Butler/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State Maryland Nat'l. Mem. Park 11/05/10 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. an. all 4925 Burroughs Ave., N.E., Washington, D.C. 20019 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Hyperten Physician Medical resulting in death) Due / r as a consequence of) Examiner te arth Sequentially list conditions, it is a subject to cause. Enter Underlying Examine Due to lor as a consequence of g physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached g 🗌 Unknown g Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy death? Yes 2 X No 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No 1 Inpatient 2 B ER/Outpatient 3 IDOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

Pe Funeral Director: A pleted filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day. Year) 29b. Signature and title of certified 11-01-2010

State Registrar

31. Date filed (Month, Day, Year,

Malika A. Fair, M.D. 3001 Hospital Drive, Cheverly, Maryland

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day28 1815 pm 10 Physician/ Bettye Jean Coley Gill Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House g. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Countroklahoma Min. 10/31/ 1 □ M 2 🏝 F 81 Director 441-28-4828 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director Upper Marlboro 1 🗌 Yes 2 🖺 No MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 20772 6912 Perrywood Rd. 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White, etc. ò 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Psychologist Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ Grace(maiden name unknown) Carl Coley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Adrian Gill - son 6912 Perrywood Rd., Upper Marlboro, Md. 20772 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/4/2010 Silver Spring, Md. 4 Donation 5 Other (Specify) Gate of Heaven 21. Signature #/Fi neral Service 22. Name and Address of Facility Eternal Faith Funeral Svc. M01576 5625 Allentown Rd., Camp Springs, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed cate has been s page 2 should Respiratory Failure 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **M**atural 5 Pending death. 1 Yes 2 No ☐ Accident Investigation after death Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only gne) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10/28/2010 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Debrah Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36083 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:09 PM Evelyn Marie Golden Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Year) 4/30/1965 Director 45 227-11-0438 Cheverly, MD Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Riverdale 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5433 56th Avenue, #1 20737 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. þ 1 Never Married 2 X Married 21215-0036 1 Yes 2 No Specify: If Yes Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Melvin Holmes Betty Ann Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph R. Golden / Husband 5433 56th Avenue, #1, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 11/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Jase Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, COPITU disease or condition Medical resulting in death) Examiner Sequentially list conditions if any leading to immediate Examiner cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a conseq resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has 1 Yes 2 No 2 0NO Yes 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DoA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury
28c. injury ၉ 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature 29d. Date signed (Month. Day. Year) MDD 60925 10130110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Road, Lanhom, MD. 20106 E112Abeth 7A31101

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36084 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV. 4, 2010 ROY N/M/N GIBSON 11:22PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4290 STRAUSS AVENUE CHARLES INDIAN HEAD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 227-40-0658 1**X** M 2 □ F Months Davs Hours Min. 41Month 9 Day 1 Year 3 6 VA^{untry)} 74 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES MD. INDIAN HEAD 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 4290 STRAUSS AVENUE 20640 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify.WHITE If Yes, Give Year or Dates 1 Tes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. PAINTING CONTRACTOR 9th SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ OTIS GIBSON BESSIE COLLINS 19a. Informant's Name/Relationship (Type, Print)
YEVON GIBSON-SPOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4290 STRAUSS AVE。 INDIAN HEAD, MD。20640 permit. Page 1 and 2 st Department of Health a Important: If item 27 is injury or other Baltimore, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 & Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
TRINITY MEM • GARDENS 11-10-10 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause in each line Immediate Cause (Final Physician na disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown s been signed by the should be detached 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an las. page 2 autopsy performed Yes 2 certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Day, Year) 225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20604 12070 moth 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 17 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBE 10.55 7 M 200 John O. Hubbard Medical . Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death BALTIMORE WASHINGTON MEDICAL mente GLEN KURTUE Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 456-46-8671 77 Director Yrs Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severn 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21144 USA 7952 Citadel DR. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

No 1953-Black, White, etc. 1 Never Married 2 KM arried Completed by Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 Yes XX No Specify: Specify 3 Widowed 4 Divorced 1975 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OR Tech NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tilda Mae Hubbard Samuel Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, MD 21144 Ella Hubbard Wife 7952 Citadel Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11/12/2010 Maryland Veteran Cem Crownsville, MD . Signature of Funeral Service Con 22. Name and Address of Facilit Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician STATIL disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the bunal-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant Unknown 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Yes 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a

To the Funeral D

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the P only one 29b. Signature

State Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#5 per FH State Registrar 11/3/2010 AACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct. 2010 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death G 00/1 e IVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. July 11 Year 942 Maryland Director 212-40 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 D Bens Drive 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: **Black** Completed 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Home Instead Elementary/Seconday (0-12) 7th College (1-4 or 5+) Home Care Aid Senior Care Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William A. Spriggs Mary Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharron Bynum(Granddaughter) 6462 Mt. Vernon Lane Glen Burnie, Md.21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 10-28-10 Metro Crematory Baltimore, Md. 4 Donation 5 Other (Specify) Miname Races Scot Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. B. Been MC6483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death D exacerbatio Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 💆 No Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sign e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 🔲 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Division of To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number ア40733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3169 Braverton St. Stell Edgewater, MD 21037 Jones

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** Joan Murphy Hurley actober 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchastel Cambridge Hospital brokester General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 31, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 □ M 2 🕱 F 220-28-0065 1932 Maryland Director Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventual be notified at once. 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 ☐ Yes 2 N No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Bellevue Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐Yes 2 No Specify. white Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) owner auto body shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Crawford O'Neill Murphy Beatrice Brohawn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse B. Hurley Jr. husband 2 Bellevue Avenue, Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 10/27/10 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur A Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician After this within 24 hours after death To the Funeral Director:

Baltimore,

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ahmed

DHMH 17 Rev 1/2001

Byrn St., Cambridge

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D65528

21613

29d. Date signed (Month, Day, Year)

10/26/201n

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician/
Medical
Examiner

Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is married other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	
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r	4a. Facility Name (if not institution, give stree	4b. City, Town, or Location of Death			4c. County of Death						
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	578-28-8979	7. Age (In yrs. le	Yrs.	Months Days Hours Min (Month Day V				20 g. Birth Cou	hplace (State or Foreign intry) DC		
_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
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Funeral Director	12803 Prestwick D	rive							States		
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Completed by	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.			Yes 2 No Specify:			Black, White, etc. Specify: African American			
olet	15. Decedent's Educat (Specify only highest grade co		16a. Deced	ent's Usual Occupa	ation	rking	16b. Kind	of Business I			
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BeC		5+	DC Public School Te					Govern	iment		
10	17. Father's Name (First, Middle, Last) John Tra	ісу	18. Mother's Name (First, Middle, M Martha					name)	(unk)		
	19a. Informant's Name/Relationship (Type, F Albert Hill - Son	Print)	1	g Address (Street a Genoa Ave		ıral Route Numbei rt Washi			^{Code)} 20744		
71	20a. Method of Disposition 1	ace of Disposition (Name of metery, crematory or other place) Lincoln Date November 2,				20c. Location - City or Town, State Suitland, Maryland					
	21. Signature of Fyneral Service Licensee	Home,	Inc.								
	23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Dementia								Approximate Interval Between Onset and Death		
	disease or condition resulting in death)										
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iysician/iv	in the past 12 months?	If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month Day Year				
a by F	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.			pacco use contribute to the cause of death?			
completed by						autop	autopsy prior 1 performed? death		opsy findings available ompletion of cause of		
פ	25. Was case referred to medical			26. Pla	ce of Death (Che		Z INU	iies	2 - NO		
2	examiner? 1 \(\sum \) Yes 2 \(\frac{\mathbf{X}}{\mathbf{N}} \) No	ital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 DOA Othe	r: 4 Nursing I	lome 5 🖾 Resid	ence 6	Other (Specif	5/)		
care:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1		28d. Describe he	ow injury oc	curred			
II ceruncar	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical	29a. Certifier 1 (Check 2 Medical Examiner: 0 only one) 3 □ Certifying Nurse Pra	On the basis of examination	and/or investig	gation, in my opinio	n, death occurred	at the time, date ar	nd place, and	d due to the ca	ause(s) and manner stated.		
	29b. Signature and title of certifier		_	29c. License	number 10102			gned (Month,			
	30. Name and address of person who complete Ivan Zama 9500 Bas										
	31. Date filed (Month, Day, Year) NOV 0 3 2010	32. Registrar's Signa				<u>, </u>	<u></u>				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROGER ELTON HARRIS NOV.6,2010 5:00P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-76-4344 46 Days Hours Min. 1/00th, 25 Year) 964 1 🛛 M 2 🗆 F WASH, D.C. Director Usual Residence of Decedent 10c. City, Town or Location WALDORF 28a-f shov 10b. Cour with the Maryland State MD. 10d. Inside City Limits Director CHÁRLES item 27 is marked other than "natural", or items 23a or 28a-fs other traumatic event, the Medical Examiner must be notified 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 3050 OUT OF PLACE Funeral 20603 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) IBEW LOCAL#26 ELECTRICIAN 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked CLARENCE ELTON HARRIS, JR. JEAN CONE 1 and 2 should to the alth and Me I item 27 is mark 9a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

CLARENCE E. HARRIS, JR.-FATHER 120 TIDEWATER PT. HENRICO, N.C. 2 Informant's Name/Relationship (Type, Print) HENRICO, N.C. 27842 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State ROPOLITAN CREMATORY 11-11-10 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If its
any injury or ot ALEX., VA. 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CORONAGEN 12524 Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 💆 Natural injury 5 Pending Accident Investigation 6 Could not be rector Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after Direc 24 hours Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within 2 To the 29b. Signature a 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

MENDE25

31. Date filed (Month, Day, Year)

ORIGINAL

12070 OLD LIME

CP2 4100 WILDURF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ND

Registrar's Signature

SMITTH

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 5, Charles Hatcher 201**°** 8:17A. M Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death **Examiner** 119 Periwinkle Court Greenbelt Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 1 🕅 M 2 🗆 F 73 Jant. 26, 1937 New Dersey 556-46-3291 **Director** Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant; If item 27 is marked other than "natural", or items 23a or 28a-f sho up, or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's Greenbelt 1 Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20770 United States 119 Periwinkle Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Anyned Forces?

1 Yes 2 No
If Yes, Give 1955–1963
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 🗌 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 18b. Kind of Business Industry United States Catholic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Conference Administrative Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Williams Francis Hatcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 119 Periwinkle Court Greenbelt, Maryland 20770 Mary Jane Hatcher -wife 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State All Souls Cemetery permit. Page Department of Important: If any injury or 11/9/2010 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonalad V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Con estive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Infarction if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown b signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No this certificate 1 Yes 2 XNo 24 hours after death.

Funeral Director; After this certificeted filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D24283 November 5, 2010 30. Name and address of person wing completed cause of death (Item 23a) (Type, Print) Muhammad Yusuf, M.D. 13631 Baltimore Avenue Laurel, Maryland 20707 32. Registrar's Signature 31. Date filed (Month, Day State Registrar back

44 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G91 1/26/2011 JH. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:50 AM Physician/ Month Ida 07 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD Harford Heritage Estates Forest Hill If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 2155-8047306 **Funeral** 95 **Director** 2/24/1914 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland notified at Director Harford Bel Air MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 must be items 23a Funeral 21014 USA 294G Canterbury Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married ۾ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3

▼ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ified within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other မ Edith Hott Jerome C. Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linwood M. Head/Son 819 Delray Drive, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) Darlington Cem. oval from State 11/13/10 Darlington, MD 21. Signature of un e al Servi 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between FND STASA Onset and Death 121 montis Immediate Cause (Final Ph, sician/ disease or condition resulting in death) 40000 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 2 No Yes 1 Yes 25. Was case referred to medical ASSISKO Be 26. Place of Death (Check only one) examiner? Hospital: CARR Other: 2 X No 1 Tes ဂ္ 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie NOVEMBE: 11, 2010

State Registrar MARPHAIL BULLIN MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

4D

39 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** BETTY JUNE HUTCHESON 1:10 2010 Α /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** EGLE NURSING & REHAB CENTER ALLEGANY LONACONTNG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01 28 1925 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Davs MARYLAND 1 □ M 2 🗶 F 218-12-5864 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Evan income traumatic event, the Madical Evan income that the reality of FROSTBURG 1 ☐ Yes 2 No Director ALLEGANY MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21532 U.S.A. 13514 OLD LEGISLATIVE ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 ₩ Widowed 4 □ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 10 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, one. 17. Father's Name (First, Middle, Last) Be VOURA LARAH SCHELL GEORGE SCHELL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19205 SHAFT ROAD FROSTBURG, MD 21532 DAUGHTER VERA WHETSTONE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FROSTBURG MEM PARK 11-09-2010 FROSTBURG, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. M00547 Sowers 60 W. MAIN ST FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TRUCTIVELUNG Physician CHADNIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2 No P.O. 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭SNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

WI 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

12690

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bobby E. Iosbaker 2010° 12:10 A M October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis HealthCare Severna Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🔯 M 2 🗆 F Months Hours Min 216-32-9207 76 **Director** Iowa Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Severna Park MD Anne Arundel 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must he I Funeral 103 Severn Avenue 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, was becedent Ever in 0.5. Armed Forces? 1956. 1 X Yes 2 □ No 1958 If Yes, Give Year or Dates. Black, White, etc. 2 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Yard Foreman Lumber Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Erwin W. Iosbaker Alma Grubb permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Iosbaker / Wife 103 Severn Avenue Severna Park, MD 21146 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, October 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 <u>Ritchie</u> Hwy, Severna Park Funeral Home Severna Park, 23a. Part 1. Ent.: the ackease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fair 1. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and -transit Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical that the death certificate be the iding p IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 1 Tes 2 No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature apolititle of certifie 29c. License number 2070693

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 20<u>10</u> Physician/ November 1 3:00 P Thomas Krzenski Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 90 Months Days Hours Min 192-12-1178 0872071920 **Director** Pennsylvania Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Suitland 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ٥ 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a most injury or other traumatic event, the Medical Examiner must be. Funeral USA 20746 3800 Walnut Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1xxYes 2 No
If Yes, Give Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WW II 1 ☐ Yes 2x No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Weather Service Cartographer year æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Patula Barney Krzenski Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Semyan / Nephew 1514 Redford Dr. Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State txx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 11/5/2010 Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon HII1 Rd. Oxon HII1, Maryland 20745 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician WHE Cerebrovascy lar Herident disease or condition resulting in death) Medical **Examiner** Cardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 g Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> h'brillotion Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Hospital or Attending Physician: The After this certificate | 2 1 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending e Funeral Director: A pleted filled in by the fi 2 Accident
3 Suicide
4 Homicide Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one)

State Registrar 29b. Signature and title of certifier

NOV 0 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

urana.

29c. License number

Road

D. 50653

GYAN C SURANA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2010 William James Kline 9:30 p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12149 Pleasant Walk Road Frederick Myersville 8. Date of Birth Sept. 9 Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Days Hours Min. Year 1934 Mary Land Director 214-30-1956 76 Usual Residence of Decedent f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medi-al Examiner must be notified at 10d. Inside City Limits Director Myersville 1 Yes 2 No Frederick Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral USA 21773 12149 Pleasant Walk Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mehrle Equilla 4 1 Kline Catherine Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Myers/daughter 12149 Pleasant Walk Road, Myersville, MD 21773 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Brethren Nov.15,2010 Harmony, Maryland 21. Signature of Funeral Service Lip ns-22. Name and Address of Facility 504 Main Street 0 Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Leutal C disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year signed by the a d be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been siç ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DY3780

Registrar DHMH 17 Rev 7/2009

21

State

church St.

Middledown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 20

300 5.

32. Registrar's Signature

Entered.

Kern E. Hohlms

11/12/10

ms 21769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hober Klenzing George Stewart 5:40 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 1 - 25 - 1942 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 ₹M 2 □ F 199-32-1021 68 Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21740 U.S.A. 16143 Spade Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1,959-Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married 1 XYes 2 Specify: White 1 ☐ Yes 2 🔀 No Specify: 1965 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Mental Hygiene. narked other than "r Elementary/Seconday (0-12) 12th grade government College (1-4 or 5+) maintennance supervisor is marked other Be 17. Father's Name (First, Middle, Last)
George Stewart Klenzing Jr. 18. Mother's Name (First, Middle, Maiden Surname) Mildred Rupert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16143 Spade Rd. Hagerstown, MD 21740 Joy Klenzing spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11-3^{ate}2010 Department of I Important: If it any injury or or ð 1 Burial 2 Cremation 3 Removal from State Broadfording Cem Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** waten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🛂 No ပု 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 106200 6

DHMH 17 Rev 7/2009

State Registrar

5H-6+1

DAVID

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

E. ANTICIAM

ST

HURGE STEWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251

32. Registrar's Signature

ANTAKO WIRODY

			per FD Please epter10-26-10 KAH - Stepstrar	State of Marylan	d / Depa		Health and M	lental Hygi	_	36098							
	Physicia Medio		1. Decedent's Name (First, Middle, Last) Stanley Losa			2. Date of Death Month October	Dav Year	3. Time of Death 4:00 A M									
Examiner			4a. Facility Name (if not institution, give s Atria Manresa		r Location of Death		4c. County of Death Anne Arunde1										
	Funeral Director		5. Social Security Number 134-14-5545 6. Sex 1 7. Age (In yrs. last birthday) 1														
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State Maryland Anne Aru	indel 10c. City	, Town or Lo	cation Ann	apolis			10d. Inside City Limits 1 ☐ Yes 2 🖾 No							
	with the Ma 23a or 28 ust be noti	Funeral Dire	10e. Street and Number 85 Manresa Dr	rive Road	10f. Zip Code 21409			10g. Citizen of What Country?									
9036	permit. Page 1 and 2 should re filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Diverse 2 No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
215-0	n 72 hou e. an "natu Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Seconday (0-12)		(Give I	dent's Usual Occup kind of work done O NOT use retired)	during most of worki	ng 1	6b. Kind of Business In	ndustry							
7	d withii lygiene ther th	a		5+	Telev	vision Ne	ws Produc		NBC								
Baltimore, Maryland 21215-0036	ud e file Mental H nar ed ot	TO B	17. Father's Name (First, Middle, Last) Albert Losak				Rache1	me (First, Middle, Maiden Surname) 1 Herschmann									
, Mar	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (Type Garnett Losak — I			-	and Number or Rura Court, Bro		ity or Town, State, Zip Y 11209	Code)							
imore	Page 1 annent of Hant of Hant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emeterv. cren	sition (Name of natory or other place Cremato	ce) !	- 1	oc. Location - City or T Baltimore,								
21. Signature of Funeral Service Licensee Whelin I, Klobat				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 214													
	Physician/	EC 0	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on pach line. 🥠			ng, such as cardiac o			Approximate Interval Between Onset and Death							
rest.	Medical Examiner	Examiner	resulting in death)	Due to (or as a consequ	onsequence of):												
90	rted J unsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequ	ience of):		Į.										
09	ite be executed hysician and he burial-transit	g															
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		hysician/Me	hysician/Me	hysician/Me	hysician/Me	hysician/Me	hysician/Me	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	Ideath 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliver Month	very Day Year
s, P.O.	ires that t signed b Id be deta		Part II. Other significant conditions con	nditions contributing to death but not resulting in the underlying cause given in Part I.					3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown								
Division of Vital Records,	ne law requ e has beel age 2 shou		Denetra			24a. Was an autopsy performe	opsy findings available ompletion of cause of										
<u>E</u>	sian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?				lace of Death (Check		No 1 L Yes	A							
Ę	Physic this coral dire	은	1 ☐ Yes 2 No H	ospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatier		4 ☐ Nursing Ho		ce Other (Specif	1103							
o uo	ending eath. or: After the funer	Certificate:	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	worl		28a. Describe now	e how injury occurred								
Divis	ital or Att ins after d al Direct led in by 1	al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office	ctory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	the Hosp in 24 hot he Funer ipleted fill	Medical	(Check 2 Medical Examina	cian: To the best of my knowler: On the basis of examination Practioner: To the best of my	and/or invest	tigation, în my opini	on, death occurred at	the time, date and	place, and due to the ca	ause(s) and manner stated.							
			29b. Signature and title of confider			29c. Licens	e number 57025	290	d. Date signed (Month,	Day, Year)							
	3/13/1/W		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	ve Ste a	231 Am	apolis	SMDa	21401							
À	Sta Registra		31. Date filed Month, Day, Year) 0CT 26 20	32. Registrar's Signat	ure	ake		1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D LAWSON 0430 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. Counfy of Death Fairfield Nursing Home Crownsville Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign West Virginia 69 226-54-0251 **Director** 1941 June | Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Waldorf Charles 1 Tes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20601 USA 11833 Oak Manor Ct. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced Year or Dates.1962-65 injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service 4 Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold Lawson Eliza Fullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, and 2 s Health (Charlotte Hall, MD 20622 Natascha E. Adriani / Daughter 13115 Charles St., permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State MD Veterans Cemetery 10/28/2010 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the se, or on plications that caused shock, or hear ailure. List only one cause on each line. Immediate Cause (Final cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Oriset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Orderlying Cause (Disease or linjury Due to (or as a consequence of) Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year ed by the a Yes 2 No 1 L Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MULTIPLE MYELOMA Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💯 nknown Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform 2 N 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer the Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident hours after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** October 0527 9 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita 6. Sex, Easton Talbot Memorial If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 28, 1957 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 217-76-7585 1 M 2□ F Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director on Talbot 10f Zin Code 10g. Citizen of What Country's 10e. Street and Number U5 A ane Funeral 60 wan's Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No ð Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Processing Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenkins ဥ Groce 0 line 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 N. WashingtonSt. Apt. 1404 Easton, MD. Emma Lewis injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2010 Hillsboro 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME, P.A. Henry Funeral Home, M.A. 510 Washington St. Cambridge, 21613 23a. Part). Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest sinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath immediate Cause (Final Myo cardial Physician nomites disease or condition resulting in death) /Medical Due or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner quence of) भाके लिखारिं। resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 □ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the functional director, page 2 should be detached after death

within 24 hours a

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

or items 23a or 28a-f show

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Jepartment

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rowle

10 32. Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 Day Physician/ $\overset{ ext{Month}}{10}$ 2010 04:19 M Ruth Maria Locks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthpic Country) Funeral Months Days Hours Min. 02 Month, Pay, 1 - M 2 X F Director 88 577-94-8605 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 Yes 2 □ No Oxon Hill MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by once. Funeral United States 20745 1509 Southview Drive Apt. T 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14 Bace - American Indian. Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 X Yes 2 □ No Specify: Cuban Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Effie Lillie Carl Nickens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Southview Drive Apt. T Oxon Hill, MD 20745 Lolita Oxendine / Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 11/04/2010 4 Donation 5 Other (Specify) Brentwood 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature Bladensburg Rd. Brentwood, MD 20722 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Dav Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed? Yes 2 X No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 1 🗌 Yes မြ 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

John Leor 10-08438	nai	d Lawhorn Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are l	_egib	ile.					
Unk Unk-		State of Maryland / Department of Health and Mental Certificate of Death	Hygiene	Reg. N	201	0 3610				
Physicia Medical Eveni		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of I Month Novem	Death		3. Time of Death 1020 hrs				
Medical Exami	ner	. <u>John Leonard Lawhorn Jr</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		_	4c. County of De					
,		7400 Marlboro Pike Forestville			Prince Geo					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M	Ain.			Birthplace (State or Foreig Country)				
Director		578-90-4391 1 M 2 F 42 Yrs. Usual Residence of Decedent	May	29	, 1968	Wash.,DC				
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
Maryland 28a-f show d at once.	Ď	MD PG Clinton		1	4148 4.0	1 Yes 2 No				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code			Citizen of What C					
vith the	al D	10411 Inez Place 20735 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or	1	ited St	nerican Indian, Black,				
death v r item	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	rto Rican, etc.)		White, etc	2.				
after		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Lo		Black				
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5-00 iled wi Hygie I other		17. Father's Name (First, Middle, Last) 18. Mother's Nam	me (First, Midd	lle, Maide	en Surname)					
121 Id be f Aental narke	o Be	John I. Lawhorn Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	r Rural Route	e Number	City or Town. Si	tate. Zip Code)				
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medical</u>	ř	I was I asham / matham 10411 Inez Place	5		ony or round o	,,				
re, N 1 and 1 and Healtl fitem		20a. Method of Disposition 20b. Place of Disposition (Name of commentary, 40 /			c. Location - City	or Town, State				
Pages Pages nent of ant: I		1 Burial 2 Cremation 3 Removal from State crematory or other place) 11/19/10 Resurrection Cemetery Clinton, M								
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HC	dges							
Physician		23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac				Approximate Interva				
/ /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries				Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated								
ansit	Ã	events resulting in death) Last Due to (or as a consequence of): d.								
e execucian an	dical	UNPENDED AMENDED								
760, icate b	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live high	UU 160	12	23d. Date of deli					
Box 68760, e death certificate b the attending physied for use as the bu	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy		Month	Day Year				
BO) e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	Loc D							
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.				e to the cause of death? Probably 4 Unknown				
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Division of Vital Records, tal or Attending Physician: The law requir 1s after death. al Director: After this certificate has been siled in by the funeral director, page 2 should t	To Be	overning?	sing Home 5	Resi	idence 6 🗸 0	ther: Scene				
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Sior Attend death.	catic	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Locatio	n /Stroo	at and Number of	Rural Route Number, City				
Divis	rtifi	3 Suicide 6 Could not be determined (Specify) Vacant Building			ke, Forestville,					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Certification:	29a. Certifier 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, a	and due to the o	cause(s)	and manner as :	stated.				
Fo the vithin to the comple	edic	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, o							
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.	DC 64E		d. Date signed (ovember 5, 2	'Month, Day, Year) 2010				
		Theoden M. King TRy M. D.	OCME		Overriber 5, 2					
		30. Name and address of person who completed cause of death (flem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21	201						
St	tate	On Designation Company								
Regist	trar	NOV 17 2018 Chama A. Jack								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) JONNA, LEE, LUM Physician/ . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHING HAGERSTOWN WASHINGTON COUNTY HOSPITA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Vest Virginia 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 233-50-9496 West Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8901 Lum's Lane 21713 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11 Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Purchasing Agent Construction other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of ဥ Irene Stotler Cain John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Terri Long / Daughter 10624 Honeyfield rd. Williamsport Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò injury (Rest Haven Cemetery | 11/06/2010 | Hagerstown Maryland 21. Sign turn of Funeral) ervice Tocensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) INFARLTION Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown 5 Other (specify) page 2 should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? or Attending Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0066092 11,03,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STLMAN 14-I M&H130013 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

NOV O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 0 Day 25 Irene S. Mills 2010 0113 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Hours 220-36-9291 Feb 14 Year 915 95 Director Maryland Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1955 Forest Drive 21401 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Force 1 Never Married 2 Married o ò 2 X No Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2X No Specify. Completed 3X Widowed 4 ☐ Divorced Black event, the Medica 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than Elementary/Seconday (0-12) Anne Arundel Co. College (1-4 or 5+) 12th 6 +Educator Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur T. Stryckning Naomi Caulk traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) alerie Mills Cooper(Daughter) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 1304 Hawkins Lane Annapolis, Md. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 又 Other (Sp配射tombment Memori Gardens 10-30-10 | Annapolis, Md. Wmame Recessed & Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ iration neumon disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No g Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2/X No Other: မ 1 Tes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Vithin 24 hours are with To the Funeral Director. Aft Certifical work Accident Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and titlé of certifier 29c. License number 29d. Date signed (Month, Day, Year) 058570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 10/26/2010 Physician/ 2:06 P Ellsworth George Merritt Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Months Hours Min. /28/1919 Country) MD Yrs Director 218-20-7323 Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director must be notified Berlin 1 Yes 2 X No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 10420 Assateague Rd. 21811 USA or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Windsor Resorts farming/ carpentry other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H မ is marked Viola Mae Pruitt George Washington Merritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Nancy Louise Cropper (daughter) 10420 Assateague Rd. Berlin, MD 21811 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₹ cemetery, crematory or other place 1 X Burial 2 remation Removal from State 5 D Other (Specify) 10/29/2010 4 Donation Riverside Cemetery Signature of Fune 22. Name and Address of Facility The Burbage Funeral Home Berlin MD 218II 108 William St. w per the disease, heart ailure. List cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. 23a. Part 1 shock, o Onset and Death Immediate dause (Final disease or condition Physician/ xxondial Medical resulting in death) (as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 attending p for use as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? has of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this Director: After this d in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Division Investigation filled in by the Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in the option, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) probella 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#23DperMD, 11/1/2010, BWW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mod 1367 pm 285 Juerra **Physician** /Medical or Location of Death 4c. County of Death **Examiner** aPlata If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth 1 04 264 261 0 **Funeral** Months Days Min 8 Maryland none 1 □ M 2 🔀 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if the Medical Experiment reast be notified at appear. 10c. City, Town or Location Waldorf 10d. Inside City Limits 10b. County 10a. State MD Charles 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20602 392 University Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican Buerto Bican etc.) In / 1 Yes 2 □ No Specify Salvadoran Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1∐Yes 2□No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name_(First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rina Elizabeth Mendez Rivas Guerra Guerra Jerson Rafael ٩ 19a. Informant's Name/Relationship (Type. Print) mother Rina Elizabeth Mendez Rivas/ 392 University Street Waldorf, Md. 20602 20b. Place of Disposition (Name of Family Cemeter) Sensuntepeque Cabanas, ElSalvador Date 20a. Method of Disposition 11/5/2010 1 ☑ Burial 2 ☐ Cremation 3 🖺 Removal from State 4 Donation Other (Specify) PHILTP ADESTINALDI FUNERAL SERVICE, P.A. 21. Signature of-E 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part I. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anencephaly 58 minutes Physician disease or condition resulting in death) /Medical Due to (or as a co sequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 1 Tyes 2 No 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached f Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 🗷 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

MO (Wiltrout)

Usa Wiltrout, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0057484

Civista Medical Center 5 Garrett Avenue Laplata, MD 20646

10/26/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Martina November 7:15 A. M Freda Virginia Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Frederick Frederick 427 Banksia Drive 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) West Virginia . Age (In yrs. last birthday) Social Security Number 8. Date of Birth Funeral Min. Months Hours 03/04/1933 236-48-2951 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director MD Frederick 1 X Yes 2 ☐ No Frederick 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number iral", or items 23a or Examiner must be Funeral 427 Banksia Drive 21701 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) office manager moving company Be permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked off any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Thelma Hott Frank Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falls Church, Va. Albert J. Martina / spouse 6069 Brook Dr., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD Smithsburg Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home ·lu Kreh MO1222 106 E. Church St. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the attending physician and be detached for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ I or Attending Physician: The law requires that the death after death. in the past 12 pronths?

1 Yes 2 No Month Dav Pregnant at time of death 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No Yes 2 25. Was case referred to medical completed filled in by the funeral director, Be 26 Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Director Suicide Could not be 28e. Place of Injury - At home building, etc. (Specify) farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)
427 BankSia home the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Ficderick MD 21703 Naja Thomas

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 201°0 10:40 PMM Louise Hauver Moss Medical County of Death Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Citizens Care & Rehabilitation Ctr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 93 Months Feb. 2. 1917 215-16-9004 Marvland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 No Maryland Frederick Thurmont 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 11038 Old Frederick Road 21788 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes XX No 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Specify. White XX Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fili.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ပ Clyde Hauver Eleanor Whisner 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11038 Old Frederick Rd., Thurmont, MD 21788 Richard W. Moss, son Method of Disposition 20b. Place of Disposition (Name of Date Mount Olivet Cemetery Nov. 11, 1 Burial 2 Cremation 3 Removal from State Frederick, MD 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Reeney and Bastord PA Funeral Home M00255 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): anding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nse s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I \$ 3 Probably 4 Unknown 1 Yes 2 No Completed 24a. Was an 24b. Were autopsy findings available s certificate has be director, page 2 s prior to completion of death?

1 Yes 2 No autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work?
1 Yes 5 Pending ithin 24 hours after death.

the Funeral Director: Ai pmpleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of co 29d. Date signed (Month, Day, Year) November 8, 2010 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar nav DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10, Month Physician/ 1:33 A M ARNOLD EZRA MORRISON JR. Vevenbor 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 3 /4 / 1930 West Virgini 213-38-8666 **Director** Usual Residence of Decedent show and Montal Hygiene.
and Montal Hygiene.
'is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD. Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 4400B Federal Hill Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify. 3altimore, Maryland 21215-0036 White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Well Driller Well Drilling any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ Morrison Arnold Bright Dahlia Mae Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 (Wife) Josephine Morrison Hill Rd. 4400B Federal 21154 Street. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 15. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jarrettsville Cem. 2010 Jarrettsville. MD 21. Signature of Funeral Service Kid 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Maryland Home. P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes been signature Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has l page 2 s autopsy 1686HOCOON certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0053568 ress of person who completed cause of death (Item 23a) (Type, Print) 30 Name and a 0 31. Date filed (Montr Year) 32/ Registrar's Signature State September 1 Registrar NH

DHMH 17 Rev 7/2009

			Please	Type or Print in Black AMEND ITEM#25,28a State of Maryland / De	indelible ink f perME, G	Ensure All Cop 909, 11/16/2010	ies Are Legible.), WS
			For State Registrar		ertificate of D		Reg. No. 36110
	Physicia Medic		Decedent's Name (First, Middle, Las Lilly	[∌] Arvella Marie Morg	an	2. Date of Month	Day Year 1200 M
	Examin		4a. Facility Name (if not institution, give WMHS - Regional		4b. City, Town, or I	Location of Death	4c. County of Death
	Funeral Director		5 Social Security Number 6 Se		Months Days	Hours Min. 8. Date of (Month)	Birth Park Year) 9. Birthplace (State or Foreign Country) MD
	ryland -f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County MD Alleg	10c. City, Town or	Location lintstone		10d. Inside City Limits 1 □ Yes 2 □ No
	h the Ma ka or 28a be notif		10e. Street and Number		10f. Zip Code	0.4500	10g. Citizen of What Country?
	ith wit ms 23 must	Funeral	17805 Morgan T		3 Was Decedent of His	21530 spanic Origin? (Specify Yes or	No- 14. Race - American Indian,
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ह	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, specify Cuban	, Mexican, Puerto Rican, etc.)	Black, White, etc. Specify: white
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pu	filed wall Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Mid	dle, Maiden Sumame)
yla	uld be I Ment narker natic e	욘	Frank Lamber				Valker) Hose
Baltimore, Maryland 21215-0036	nd 2 sho lealth and m 27 is r her traun		19a. Informant's Name/Relationship (Ty Charles Morgan	Sr. husband	17805 Morg	an Trail Lane F	
more	Page 1 anent of Hant of Hant If ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other \$peqif	Removal from State cemetery, o	sposition (Name of rematory or other place ty Cemetery	Date 11/1/2	20c. Location - City or Town, State Plintstone MD
Balti	permit. Departn Imports any inju		21. Signature of Fineral Service Vicens	ee		elli Funeral Home, P.	
			23a. Part / Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the death. Do not ene cause on each line.	enter the mode of dying		y arrest, Approximate
	Physician/ Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	uma		fall
1	_	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):			
yo	oe executed ician and ourial-transit	l Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a consequence of):			111
90	10 -	dical	•	d			Della silitio
Box 68760	death certificate bu he attending physic ed for use as the b	Physician/Medi	in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	hat the ed by th detache	by Phy	g ☐ Unknown Part II. Other significant conditions co	ontributing to death but not resulting in th	e underlying cause give	en in Part I. 23e. D	id tobacco use contribute to the cause of death?
rds, I	aw requires that the death as been signed by the atte 2 should be detached for	ted b					Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	i cian: The law r certificate has b rector, page 2 sh	Completed				p	/as an utopsy findings available prior to completion of cause of death? lambda 24b. Were autopsy findings available prior to completion of cause of death? lambda 24b. Were autopsy findings available prior to completion of cause of death?
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of Vi	Physi r this c eral din	e: To	1 A Yes 2 12 No 27. Manner of Death	1 Inpatient 2 I ER/Outpa	e of 28c. Injury	4 ☐ Nursing Home 5 ☐ F at 28d. Descri	lesidence 6 Other (Specify) pe how injury occurred
on (ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation				ell in Bathroom
Divisi	al or Attus s after de al Directo	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify) residence	street, factory, office	28f. Location City or Lane,	on (Street and Number or Rural Route Number, Town, State) 17805 Morgan Trail Flinstone, MD
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in se Practioner: To the best of my knowledg	estigation, in my opinion	n, death occurred at the time, da	ate and place, and due to the cause(s) and manner stated.
	To the Cool of the		29b. Signature and title of certifier	Lummo	29c. License	070974	29d. Date signed (Month, Day, Year)
	5			completed cause of death (Item 23a) (Type		CT EAR ALL	MAERIAND MA DIEM
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	KOOK KD.	215:200 M	MBERLAND, MD 21502
	Registra	ar	MOV 16 2010 Des	www . parket			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FoAmend Item #5 State of Mary State RegistraWCHD/SH 11/4/10 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Evelyn Miller 0224 Daisy 13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Maryland **Director** 70 1940 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tiff item 22 3a or 28a-f show and tiff item 27 is marked outher than "natural", or items 23a or 28a-f show ury or or other traumatic event, the Madical Examiner must be notified at ury or orther traumatic event, the Madical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 11 W. Baltimore St. 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Health Care Provider Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Hazel D. Werdebaugh Thomas Hensley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel M. Powell/Daughter 3428 West View Circle, Greencastle, PA 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Cedar Lawn Mem. Park 11/4/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Mu 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ SEPS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events to for as a consequence of, attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peens 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director: After this certificate has liftled in by the funeral director, page 2 st autopsy performed death? 1 Yes 2 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State)

within 24 hours a completed

5H-2 State

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

60M M

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DO065024

251 E. Antietam St., Suite 8057, Hagerstown,

29d. Date signed (Month, Day, Year) 311

2010

21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Burge Matthews 5:00 ДМ October 27, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Asbury Methodist Village Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 106 Mt. Vernon, IA 214-32-9595 August 15, 1904 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XiYes 2 □No Director Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 301 Russell Avenue 20877 23a Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other them any injury or other trainment. items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tyes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White 2 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Banking Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Metta Bell Russell James Louis Burge ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1248 Weller Way, Westmister, MD 21158 Shirley M. McKeown / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/2010 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 0 RAY Roges Approximate Interval Between Onset and Death 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. on restive heart arture Immediate Cause (Final Vacuuck **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Carmyartery Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Usterarth 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☑No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending ours after death.

neral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Maccident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day, Year) OCT 2 9 2010

V. Rober Dus Mbas

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENUE (N. 120BERT BIRSCHBACH, UND GAITHERSBURG, WID 208117) IS. ROBERT BIRSCHBACH, UND 32. Registrar's Signature

Kess

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:00p._M Physician/ Evelvn Estelle NAUGLE October 30, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Nursing Home Williamsport Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 224-22-7894 89 Virginia Director Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1352 Delaware Lane 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married ģ ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 5 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) factory worker dress factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard L. Lumpkin Gertrude T. Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Moore - daughter 224 Woodpoint Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Entombment 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Minnich Funeral Home Tof Funeral Service Licenses 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Advances Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 XNO 1 🗆 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 16 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 2 nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name No Thern H Mi 31. Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 17, 2010 Anthony Ike Onunaku 4: 36a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1838 Metzerott Road Apt. Adelphi Prince George Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Min. Months Hours 05 - 25 - 1 956 Director 578-23-7930 54 Nigeria Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 🌠 Yes 2 □ No Prince George Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1838 Metzerott Road Apt. 1114 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Taxi Driver Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Benedict N. Onunaku Jenet James Ahanonu 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francisca Uduaku Nzekwe 9901 Hilgert Drive Cleveland, Ohio 44104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Family Cemetery 11-04-2010 Port Harcourt, Nigeria 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, INc. Catricia Raine 3447 14th St. N.W. Wash. DC 20010 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sudden Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or ilnjury that initiated events sician and bunial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the bunal Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) detached 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be Essential Hypertension, Congestive Heart Failure 2 No 3 Probably 4X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Microcytic Anemia 24a. Was an Physician: The law After this certificate has page 2 autopsy performed? 1 ☐ Yes 2x ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred or Attending X Natural (Month, Day, Year) To the Hospital or Autonom.

Within 24 hours after death.

To the Funeral Director: Aft 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-68964 10/28/2010 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Annapolis Road

State

Registrar

MANASH 31. Date filed (Month, Day, Year) DAJ

egistrar's Signat

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NOV 01 2010

Landover Hills, Md. 20784

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<u>გ</u>	and 2 Health		Candace Alison Conwa	ay/wite	20h Di		sition (Name of	nue, s				on - City or To	un State	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐		ce	metery, cren	natory or other place		Nov. 2010	2,		r Sprino		
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بر	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):								
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₹ V	Phys rthis ral dii	<u>ان</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of injur	у 2	28b. Time of	it 3 🗆 DOA	4 L N		e 5 Resid)	
o u	nding Ith. : After e fune	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year)	injury	work	? Yes 2 □						
Division of Vital Records, P.O.	Atter er dez ector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	oe Place of Injur		ne, farm, str	eet, factory, office		28	f. Location (S City or Town		nber or Rural	Route Number,	
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Very the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exam	vsician: To the best of r niner: On the basis of ex	amination	and/or invest	tigation, in my opinic	on, death o	occurred at th	e time, date ar	nd place, and	due to the car	use(s) and manner	stated
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	,		30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type, F	Print) Silver Sp	rina	MD 500.	10				
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31. Date filed (Month, Day, 1 Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:20 Charles Edward Offutt 2010 October 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Sanctuary at Holy Cross **Burtonsville** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday **Funeral** 1 X M 2 □ F Months Hours 579-38-4020 79 Director Usual Residence of Decedent Fshow th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's New Carrollton 1 🔀 Yes 2 🖵 No ō 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20784 5815 Lamont Drive . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. res, Give Year or Dates. 1953–1956 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Theresa Desmond Charles Edward Offutt, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joanne Lee Offutt / Wife 5815 Lamont Drive, New Carrollton, MD 20784 1 and 2 s of Health item 27 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Page 1 5 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or Metropolitan Crematory 11/7/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Physician/ Cerebral Thrombosis disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown the detached P.0. signed by tid be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Difficile Colitis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dysphagia certificate has autopsy death? page performe Sacral Ulcer 1 Yes 2 No 2 X N Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 5 \square Pending 1 X Natural 1 Tes 2 🗌 No death. Accident Investigation 24 hours after death completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

oct 2 9 2010 State Registrar

29b. Signature and title of certifier

ellell

Tasneem Lakhani,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith Avenue, Baltimore, MD 21209 32. Registar's Sig

29c. License number

D28595

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, 2010 11:55 October 0 а Izrai1 Podrabinnik Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country) Russia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Months Days Hours 81 212-47-0661 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 X Yes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 12630 Viers Mill Road #515 20853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **Mechanical** Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Basya Krasnik Moisey Podrabinnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12630 Viers Mill Rd, #515, Rockville, MD 20853 Dora Rozovskaya / wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Judean Memorial Gdns | 10/28/2010 | Olney, Maryland Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 20852 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 24 hours Immediate Cause (Final Septic Shock disease or condition resulting in death) Due to (or as a consequence of): Small Bowel Obstruction Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

Physician/ Medical Examiner

Funeral

Director

or 28a-f shov

ral", or items 23a or 28a-f sho Examiner must be notified at

er than "natural", the Medical Exar

I Hygiene.

should be file and Mental H is marked of

permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev

Baltimore, Maryland 21215-0036

and attending physician a for use as the burialsigned by t cate has been sig page 2 should b To the Hospital or Attending Physician: Nwithin 24 hours after death.
To the Funeral Director: After this certifica completed filled in by the funeral director, to

Be မ

ivision of Vital Records, P.O. Box 68760

I				_	1 ☐ Yes 2 😾 No	1 Yes 2 No
I	25. Was case referred to medical	-		26. Place of Death (Che	ck only one)	
I	examiner? 1 Yes 2 No	lospital: 1 😡 Inpatient 2 🗌	ER/Outpatient 3 🗆	DOA Other: 4 Nursing H	lome 5 Residence 6 C	Other (Specify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occ	urred
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, facto	ory, office	28f. Location (Street and Nur City or Town, State)	nber or Rural Route Numb

ertificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	red			
2	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory)	ory, office	28f. Location (Street and Number City or Town, State)	tion (Street and Number or Rural Route Number, or Town, State)			
Medica	(Check 2 Medical Examine	r: On the basis of examination	n and/or investigation, i	in my opinion, death occurred	nd due to the cause(s) and manne at the time, date and place, and due ce, and due to the cause(s) and ma	e to the cause(s) and manner stated			
	29b. Signature and title of certifier	1 nD	2	9c. License number 6/4/22	29d. Date signed	d (Month, Day, Year) 26/20/0			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Christian Healy, MD, 6410 Rockledge Drive, Suite 200, Bethesda, MD

State Registrar 31. Date filed (Month, Day, Year,

MOV 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ Jeraline Pinkney 2010 8: 26AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Min 09/21/1936 1 M 2 X F 578-50-0310 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Suitland MD Prince Georges 1 X Ves 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Funeral 20746 USA items 23a 6502 Clayton Lane Dr. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give "natural", Completed 3 K Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16h Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Wocdies Retail permit, Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 HonJohn Brown Earline Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20783 2256 Hammon St. Hyattsville, MD Katherine Cunningham/Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Harmony Cemetery 10/30/2010 Landover 4 Donation 5 Other (Specify) 22. Name and Address of Facility 20019 Signature of Funeral Service Licenses Dunn&Sons 5635 Eads St. NE Washington, DC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Schem disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** eare Gequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 Yes 2 No Month Vear Day 4 Pregnant at time of death 9 Unknown Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 4 thknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No s after death. Investigation Accident the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi Medical Examinery on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 29c. License number 29b. Signature and tity of certifier completed cause of death (Item 23a) (Type, Prince 30. Name and address of person wh

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

2010

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fred Douglas Penny Month Physician/ 0630AM 2010 rtobe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 12/31/1923 1 🕅 M 2 □ F Months Hours Min North Carolina Director 242-24-3608 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If tien Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me iteal Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Prince George's Lanham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9749 Good Luck Road #4 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status rmed Forces?

Yes 2 \(\subseteq \) No Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes Give Specify 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Truck/Cab Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Corina Leach Levy Penny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 9749 Good Luck Road #4, Lanham, MD 20706 Rhonda Douglas (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Svc:11/2/2010 Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, P.A. Signature of Funeral Service Licer 9013 Annapolis Road, Lanham, MD 20706 23a, Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician ACu disease or condition resulting in death) au Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): physician the burial 'ulmonary Physician/Medical Division of Vital Records, P.O. Box 68760 use as nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform certificate l 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2000 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

State Registrar

14300 Gallant Fox Lane, Suito 222. 31. Date filed (Month, Day, Year) NOV 0 2 2010

who completed cause of death (Item 23a) (Type, Print)

BOWIE, MI), 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/29/1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🗓 F 54 232-90-3662 OHIO Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No BERKELEY WV BUNKER HILL Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number items 23a or 25413 USA 489 TORYTOWN ROAD Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner filed within 72 hours after 1 ☐ Never Married 2 🗓 Married 1 ☐ Yes 2 ☐XNo WHITE Maryland 21215-0036 ь Specify Specify: ð 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
CO-OWNER 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) SIGNS & DESIGNS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIRGINIA MARY DICHIERA STERLING DORMAN FINK မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOSEPH DAVID ANTHONY POTTER/SPOUSE 489 TORYTOWN ROAD, BUNKER HILL, WV 25413 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, NOV. Date 20a. Method of Disposition 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State BUNKER HILL CEMETERY BUNKER HILL, WV 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, Cose 327 W. KING ST., MARTINSBURG, WV 25402 70100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 X Yes 2 🗌 No 1 Tes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 □ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient မ this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury Certification: s after death. il Director: After t (Month, Day Year) Injury 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign ture and titl 000 and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 mie tV 31. Date filed (Month, Day.) 32. Registrar's Signature

DHMH 17 Rev 1/2001 3/6

State Registrar

10-08558 Walter Prather	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene						
	1- For State Certificate of Death Reg. No.	2010 3612					
Physician/ Medical Examiner		Year 0835 hrs					
and the same	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cour	nty of Death					
	Western Maryland Health System Cumberland Allega 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/Y)	any YYY) 9. Birthplace (State or					
Funeral Director	119–48–8833 ₁ X _M ₂ F 55 _{Yrs.} Months Days Hours Min. 07/01/1955	Foreign Alabama Country)					
>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
id Ee.	MD Allegany Cumberland	1 Yes 2 No					
the Maryland as or 28a-f she tiffed at once	10e. Street and Number 10f. Zip Code 10g. Citizen of	What Country?					
23a or notifie		USA ace - American Indian, Black,					
r death with or items 23 must be no	1 Never Married 2 Married 2 Married 1 Yes 2 No	/hite, etc.					
s after c	Wildowed 4 A Divorced in res, Give real 1 fee 2 A No specify: Spec	fy: Black f Business/Industry					
72 hour 1 "natu	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of during most of working life. DO NOT use retired)						
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	10 Laborer Re 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surna	staurant					
215-(be filed on that Hyg rked oth ont, the	17. Father's Name (First, Middle, Last) Walter Prather 18. Mother's Name (First, Middle, Maiden Surna Frances	Rudolph					
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 1	Fown, State, Zip Code) 14611					
re, N s 1 and f Health If item	1 Purish 2 Compation 3 Pamoval from State crematory or other place)	on - City or Town, State					
timo t. Page tment o rtant: 1	4 Donation 5 Other Specify: Falls Cemetery 11/1//2010 Gre-	ece, NY					
Ball permit Depar Impor injury	22. Name and Address of Facility Adams Family Fu 404 Decatur Street, Cumberlan						
Physician // // // // // // // // // // // // //	23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.	Between Onset and					
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cardiomegaly Due to (or as a consequence of):	Death					
<u>.</u>	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):						
ed nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last						
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0, be execusion and suician and burial - tra							
c 68760, a certificate be ending physici use as the burician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	e of delivery n Day Year					
Box 68760, the death certificate be executed the attending physician and red for use as the burial - transit hysician/Medical Ex							
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ion o tending eath. for: Afte the fune	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No						
Division of Vital Records, pital or Attending Physician: The law requirement after death. In the properties of the prop	3 Suicide 6 Could not be determined (Specific) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nur or Town, State)	mber or Rural Route Number, City					
series of the se							
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (A)							
≥		er 9, 2010					
	30. Name and address of person who completed cause of death (Item-23a)						
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registrar	MIN 7 MIN /						

P.O. Box 68760, Division of Vital Records. this

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 8:50 P M JEANETTA MARTELL PRITTS NOV. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DEVLIN MANOR HEALTH CARE CENTER CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC. 6, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 □ F 84 Yrs. 431-38-5754 1925 KEYSER, WV Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be retified at 1 ☐ Yes 2 X No Director MD ALLEGANY LAVALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 716 BRADDOCK AVENUE 21502 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ WHITE 3 X Widowed 4 ☐ Divorced Completed filed within 72 ho I Hygiene. other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; If item 27 is marked other than any Injury or other traumatic event, Iffal. 2006. HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FELIX MARTELL LOUISE (LIKENS) MARTELL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM A. PRITTS, JR. SON 15506 BRUNSWICK CT., SW, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MDVA ROCKY GAP NOV 15,2010 FLINTSTONE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HAFER FUNERAL SERVICE, P.A. 23a. P. rt. Enter the disease or complication that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. 1302 NATIONAL HWY., LAVALE, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4week **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ ₩0 Day Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4_Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After to 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 - Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 11, 2010 00017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJBSIINO MO 22 Net'1 Ly U zte 170 2150 m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar WUV & & GUIC Consultant.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			State of Maryland / Departm 1 - State Registrar Certific	nent of He cate of De		lental Hygie Reg.	2010	36124
	Physicia		Decedent's Name (First, Middle, Last) DOROTHY EVELYN POUGH			2. Date of Death November		3. Time of Death 4: 45 A M
	Medic Examin		4a. Eacility Name (if not institution, give street and number) 4b. (CIVISTA MEDICAL CENTER)		ocation of Death	10.00	4c Gounty of Dear	th/
	Funeral Director			Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth 1/Mo/2/h4/Day/1Y@	9. Bir	thplace (State or Foreign
	show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		TON.			10d. Inside City Limits
:	the Mary or 28a-f	Funeral Director	MD. PRINCE GEORGES FORT WA	f. Zip Code			. Citizen of What Co	1 X Yes 2 □ No ountry?
:	eath with tems 23a er must t	Funera	7200 JAYWICK AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	2074	panic Origin? (Spe	cify Yes or No-	S.A.	
0000	rs after d ıral", or i Examine	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	specify Cuban, es 2X No	Mexican, Puerto I Specify:	Rican, etc.)	Black, Whit	
)-CLZL	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It fiem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SERVI 12 SERVI	Usual Occupation of work done during the control of	rina mast of worki	ng	b. Kind of Business	Industry
ana	be filed w ental Hygi ked othe ic event, i	To Be	17. Father's Name (First, Middle, Last) LEONARD J. FLEMING	1		e (First, Middle, Maid E FRANCE	-	N
Mary	2 should Ith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type, Print) ALMA MARIE FLEMING-DAUGHTER 7200	iress (Street and	d Number or Rura	I Route Number, Cit	y or Town, State, Zi	p Code) , MD . 20744
more,	Page 1 and nent of Hea int: If item iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	(Name of		nate 20e	c. Location - City or	Town, State
Baitimo	permit. Pag Departmen Important: any injury once.		21. Signature of Fineral Service Licensee MOO 479 RAY LA	MOND F PLATA,	ÜNERAL MARYLAI	SERVICE ND 20646	, P.A.	
ورد	nysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Approximate Interval Between Onset and Death
1	Medical Examiner		disease or condition resulting in death) a. Due to (or as sequence of):	ory f	A Duna	11621-		110
	ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Lale	potio	- 12)		
2	icate be executed physician and s the burial-transit	edical Ex	that initiated events resulting in death) Last Due to (or as a consequence of): d.	nary	Hyper	tonsis)n	
BOX 08/0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		opic pregnancy er (specify)			23d. Date of de Month	elivery Day Year
Э.	es that the signed by be detacl	þ	Part II. Other significant conditions contributing to death but not resulting in the under	ring cause giver	n in Part I.			o the cause of death?
Records,	law requir nas been s e 2 should	Completed	Congestive Feat	- ta	rlure	. 24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
VItal Ke	rian: The artificate h ctor, page	Be Cor	25. Was case referred to medical examiner?		ce of Death (Check	performed 1 Yes 2 only one)	d? death? No 1 ☐ Ye	s 2 No
or VI	ig Physic ter this ce neral dire	<u> </u> 2	1 Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	DOA Other; 28c. Injury a work?	4 U Nursing Ho	me 5 Residence		cify)
DIVISION	• Attendir er death. ector: Af by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined	1 □ Y€	es 2 🗆 No	28f. Location (Stree City or Town, S		ıral Route Number,
בַּ	ospital or hours aft uneral Dii ed filled in	Medical C	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, d	date and place, an	d due to the cause(s	s) and manner as st	ated.
:	To the H within 24 To the FI complete	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death		time, date and plac	e, and due to the cau	use(s) and manner as	s stated.
			30. Name and address of person who completed cause of death (kgm 23a) (Type, Print)	D-5	11/08	, (//-08	1, Day, Year) - 2010 0002
	Sta Registr		Abbas Omais MD 7C Post OFFIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature	€ Kd.	Wale	dort 1	UD J	0007

DHMH 17 Rev 7/2009

Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Hazzard Quillin State of Maryland / Department of Health and Mental Hygiene 2010 36125 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day October 26, 2010 Medical Examiner 1058 hrs Robert H. Quillen, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1532 Teal Drive Ocean City Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 02/14/1953 214-52-1158 57 1 X M Country) Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Worcester Ocean City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1532 Teal Dr. 21842 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married White etc. 1 Yes 3 Widowed Specify: White 4 Divorced If Yes, Give Year Yes 2X No specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical MD 21215-0036 package goods store clerk and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hy int: If item 27 is marked of r other traumatic event, th Be Robert H. Quillin, Evelyn Armstrong ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10813 Rippon Lodge Dr. Fairfax, VA 22032 Laurette Rash (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crem. 10/29/2010 Frankford, DE Department or Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility The Burbage 108 William St. Berlin, MD ature of Funeral Service Licer Physician hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line een Onset and /Medical a Intraoral Shotgun Wound Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the 1 Live birth igned by the attending be detached for use as 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✔ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes Inpatient ER/Outpatient 3 DOA 28a. Date of Injury FOUND: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self Natural FOUND: 5 Pending Yes 2 V No To the Funeral Director: the Oct 26, 2010 1041 hrs 2 🔲 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗹 Suicide Could not be or Town, State) 1532 Teal Drive, Ocean City, MD determined (Specify) vard 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E October 27, 2010 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCMF 2006

State Registra

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anita ROSENSTADT October 0 2010 11:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Mary land **Funeral** Age (In yrs. last birthday) (Month, Day, 1 - M 2 - F Min. 218-12-6507 86 **Director** Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Potomac 1 🗆 Yes 2 🕅 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 11500 Gainsboro Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🄀 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: "natural" Completed 3 → Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame)
Mary Moses 17. Father's Name (First, Middle, Last) Samuel Rosenzweig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 Marbury Road, Bethesda, MD Amy Rosenstadt Stoleru, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of I 1 to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 11/01/10 Olney, MD 21. Signature of Funera Service Lice 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Myocardial Infarction -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sinoatrial Dysfunctjion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): nding physician and use as the burial-transit Acute Renal Failure requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 130AM P.O. ed by til detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Dementia 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 0 autopsy performed? death? 30/ 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: Assisted 4 Nursing Home 5 Residence Other (Specify) <u>ئ</u> 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living X Natural 5 Pending work Division OSENSTAD7 1 Yes 2 No neral Director: A I filled in by the fi 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical completed fill 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) SUDARSHAN SIVA MO 10/30/10 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20814 Sudarshan Siya, M.D., 8600 Old Georgetown Road, Bethesda, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Mary		artment of F tificate of E		Mental Hy		2010	36127
Physicia	nn/	1. Decedent's Name (First, Middle, Last	,				2. Date of De Month	Reg. No.	Year	3. Time of Death
Medi	cal	4a. Facility Name (if not institution, give	Celia Roser	iseld	45 Cit Town	I and the second	Octob		2010	11:32рм
Examir	ner	917 Lamberton				Location of Death		4c. G	ounty of Death Mon	tgomery
Funeral Director		5. Social Security Number 6. Se		rs. last birthday) 101 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v, Year)	0.014	place (State or Foreign itry) Poland
	L	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Loc	ation		101/20/	7707		10d. Inside City Limits
arylan 8a-f sh ified a	Funeral Director	Maryland Montgo		. Oity, lowil of Lot		ver Spriv	10			1 Yes 2 🗓 No
the Na or 28	١٥	10e. Street and Number	mile cy [10f. Zip Code	iet spiai	19	10g. Citize	n of What Cou	ntry?
th with ms 23a must	ınera	917 Lamberton		Transfer		20902			u.s	
partitioned, IMaryliand ZIZIO-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2 🏿 No		pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White, ecify:	
2-Ur	plete	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	lent's Usual Occupa kind of work done d	ation	kina	16b. Kind	of Business In	
ithin 72 ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	O NOT use retired)	emaker	Ming		Own 1	Hamo
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yiand Ild be filed I Mental Hy narked oth	욘		ak Hollander				Sara I			
Mar 2 shou th and 27 is n traum		19a. Informant's Name/Relationship (Ty) Phyllis Teitelbai			ng Address (Street a					code) yland 20902
1 and 2 s of Health fitem 27 i		20a. Method of Disposition	20	Ob. Place of Dispo			Date		ition - City or To	
L. Page 1 tment of tant: If i		1 Burial 2 □ Cremation 3 Donation 5 □ Other (Specify)	Removal from State	ritz Ha	Chain Cer	m. 11/0				h, Israel
Departition on the control of the co		21. Signature of Funeral Service License	mell							Home, Inc. ng, MD 20904
Physician/ Medical Examiner pue patrone	edical Examiner	23a. Part 1. Enter the \(\)tisease, or comp shock, or heart failule. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Pulmonation but to (or as a condition) b. Due to (or as a condition) Due to (or as a condition) Due to (or as a condition) Due to (or as a condition)	uy Edema sequence of): u Heart I sequence of):		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	d	Fetal death 3	Ectopic pregnanc Other (specify)	у		230	d. Date of deliv	ery Day Year
s that t gned b	by P	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
e law requires has been sig ge 2 should b	eted	\ <u>-</u>				-				bably 4 Unknown
The law icate has I	Completed						1 🗆 Yes	psy ormed?		psy findings available mpletion of cause of
Physician Physician r this certifi ral director	E: To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of injury	2 ER/Outpatien	nt 3 DOA Othe	4 ☐ Nursing H	lome 5 🗓 Resident)
ending eath. or: Afte	Certificate:	1 X Natural 5 Pending 2 Accident Investigation		r) injury	work'		Zod. Describe i	iow injury or	ocurred	
ital or Attending Plans after death. ral Director: After the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Sp.	ecify)			City or Tov	vn, State)		Route Number,
ne Hosp n 24 ho ne Fune pleted fi	Medical	(Cleck 2 Medical Examin	ician: To the best of my k ner: On the basis of examin a Proglicator To the basis	nation and/or invest	tigation, in my opinio	n, death occurred	at the time, date a	and place, ar	nd due to the ca	use(s) and manner stated.
Voithit To the	_	29b. Signature and title of certifier	-ch. 1.	\bigcap	29c. License				signed (Month,	
		30. Name and address of per on who c	ompleted cause of death	1 J		D25085		0ct	tober 2	9, 2010
			. 10301 Geor	raia Aver	nue. Suit	e 301. S	ilver Si	oring.	Maryl	and 20902
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	Kel.					

DHMH 17 Rev 7/2009

		•	1 - State Registrar		,	Cer	tificate of l	Death		Reg. No.		
	Physicia	m/	1. Decedent's Name (First, Midd	lle, Last)					2. Date of Do	eath	Vari	3. Time of Death
	Medic		Silvia Roque						October	29, ^{Day} 201	O Year	4:4 9 a ^M
	Examir	ier'	4a. Facility Name (if not institution		ber)			r Location of Deat	h	4c. County of Death		
	Francis		Holy Cross Hospi 5. Social Security Number	tal 6. Sex	7. Age (In yrs. I	ast hirthday)	Silver	Spring If Under 24 Hrs	. 8. Date of Bi		on toomer	
	Funeral Director		438–51–4545 Usual Residence of Decedent	1 □ M 2 🖾 F		O Yrs.	Months Days	Hours Min.			9. Birthp Count Hor	lace (State or Foreign in) iduras
	and show	ō	10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryl 28a-f otifie	rec	MD P.	G.	Be1	tsville						1 🗆 Yes 2 🖺 No
	with the 23a or 2	Funeral Director	10e. Street and Number 11412 Cherry Hi	11 Road, Apt.	204		10f. Zip Code 20705	_		10g. Citizen USA	of What Coun	try?
	death items ier m	Fun	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.S	S. 13. \	Vas Decedent of H f Yes, specify Cuba	dispanic Origin? (S	pecify Yes or No	- 14. F	Race - America	
21215-0036	urs after oural", or	ted by	1 Never Married 2 X Married 3 Vidowed 4 Divorce	arried 1 Yes	2 XX No		Yes 2 No	_	bnduran	Spec	Black, White, e	hite
15-(72 hoi 1 "nat ledica	Completed		ent's Education hest grade completed)		(Give	lent's Usual Occup kind of work done	during most of wo	rking	16b. Kind o	f Business Inc	lustry
12	ithin lene. r thar	5	Elementary/Seconday (0-12)	College (1-	-4 or 5+)	life. De	O NOT use retired) Nurse			Medi	cal	
bd	iled w othe othe	Be	17. Father's Name (First, Middle			1	TIGEDO	18. Mother's Na	me (First, Middle			
/lar	d be f Vienta arked atic el	욘	Pablo Flores					Maxima	Reyes			
So of the pattern of												
Baltimore,	Page 1 an nent of He int: If iten iry or oth	e_ 15	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		State C	emetery, cren	sition (Name of natory or other place L Memorial		Date 2,	20c. Location	on - City or To	wn, State
Balti	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.									e Inc.	MD 2090)1
			23a. Part 1. 3 ter the disease, shock, or heart failure. List	or complications that of	aused the leat	h. Do not ente	r the mode of dyin	ng, such as cardiad	or respiratory a	rrest,	115 2050	Approximate
	Physician/		Immediate Cause (Final disease or condition			c Cardio	wascular D	isease				Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a consequ	uence of):						
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	si O sc	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury	Due to (or as a consequ	uence of):					- 1	
	al-trar	Exa	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):						
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8760	ing physician and e as the burial-transit	Medical Examiner	IF FEMALE:									
Box 6	ath ce attend for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, out 1 ☐ Live I 4 ☐ Pregi 9 ☐ Unkn	Birth 2 ☐ Feta nant at time of d	death 3	Ectopic pregnand Other (specify)	су			Date of delive Month	ry Day Year
P.0.	that the		Part II. Other significant condit	tions contributing to de	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	obacco use co	ontribute to the	e cause of death?
S,	requires that the de been signed by the should be detached	edb	Diabetes, Hypert	ension	***				1 🗆	Yes 2 No	o 3 🗆 Prob	ably 4 🔀 Unknown
Division of Vital Records,	The law req ate has bee page 2 shor	Completed by							24a. Was auto perf		prior to con death?	sy findings available npletion of cause of
<u>~</u>	ician; The certificate ector, pag	Be C	25. Was case referred to medica	1			26 PI	ace of Death (Che		2 🔀 No	1 Yes	2 🗆 No
Vit.	ys di is	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2 🗗	ER/Outpatien	0.1	or:	lome 5 Resi	dence 6□C	ther (Specify)	
o	ng Ph fter th ineral		27. Manner of Death 1 ♣ Natural 5 ☐ Pend	28a. Date		28b. Time of injury	28c. Injur	y at	28d. Describe			
ion	Attending ar death. ector: After by the funer	iţic		tigation			M 1 🗆	Yes 2 ☐ No				
ivis	lor At after o Direct	Certificate:		mined 28e. Place	of Injury - At ho ig, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To	Street and Nur vn, State)	nber or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	Medical	(Check 2 ∟ Medical	g Physician: To the be Examiner: On the bas g Nurse Practioner: 1	s of examination	and/or invest	igation, in my opinic	on, death occurred	at the time, date.	and place, and	due to the cau	se(s) and manner stated
	To the within 2 To the comple	2	29b. Signature and title of pertifi		o the best of my	/ Knowledge, c	29c. License		ace, and due to tr	29d. Date sign		
	2		► Cell	red ES	ungs /	.P.		D68904		October	29, 201	0
			30. Name and address of person				nint) Silver Sp	oring, MD 2	0910			
	Sta Registra		31. Date filed (Month, Day, Year)	32 Re	egistrar's Signat		Jest.					

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Edna Ruth Robinson October 6:00 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min. Virginia 1070971924 Director 577-34-2516 86 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland| Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 North Leisure World Blvd #1016 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Retail/Women's Clothing Store Elementary/Seconday (0-12) College (1-4 or 5+) 4 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses Offenberg Ida Swersky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald I. Robinson, son Lamont Street, NW, Washington, DC 20010 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Remembrance
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Departion 5 Other (Specify) Clarksburg, MD 21. Sion 1 1 f Eurieral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC MO1255 1091 Rockville Pk, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Cancer Medical Due to if as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): by the attending physician and ached for use as the burial-fr nsit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown 9 Unknown ò been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pancreenc Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sow H0065661 27

Registrar

State

1801 Prince Phillips Drive, Olney, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stewin D.O.

2016

20852

10-084	31	
Shiela	Mary	Royster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1- For State Registrar	Certifica	ate of Death		Reg	ı. No.	
Physici		Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
Medical Exami		Shiela Marie	1.	Loyster		Month November	Day Year 4 , 2010	0739 hrs
		4a. Facility Name (if not institution, give street and numb			r Location of Deat	h	4c. County of Dea	ath
		Southern Maryland Hospital		Clinton			Prince Georg	ge's
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birt	hday) If Under 1 Ye	ar If Under 24Hr	s. 8. Date of Birth		Birthplace (State or Foreign
Director		212-66-414U 1 M 2 XF		Yrs. Months Da	ys Hours Mir	1		Country)
		Usual Residence of Decedent	55	. 113.		70-7-	1938 1	Manyland
any		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
* .		M 1 1 2 C	(1	MA 11				1 Yes 2 No
faryland 28a-f show	횴	Maryland Prince George	Apper	Marlbu	- 3	110	g. Citizen of What Co	unto/2
Man Man	ř	0 1	1 1	101. 21p code		109	g. Citizen of What Co	dikiy:
23a o	<u>_</u>	5300 Eleanor Brooke	MAY		6772		USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Force		 Was Decedent of H If Yes, specify Cuba 			14. Race - Ame White, etc.	erican Indian, Black,
or in	Ē	1 Yes	2 🗙 No					i 1
s afte	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X N			Specify: \(\)	hell
215-0036 be filed within 72 hours after nata Hygiene rked other than "natural"; etch other than "natural"; the Medical Examiner.	þ	15. Decedent's Education (Specify only highest grade of		Decedent's Usual Occupa during most of working life			16b. Kind of Busines	s/Industry
36 n 72 usn tical	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	11.				1.
With With Med	E	12		Homen	leez	e (First, Middle, M	Dome	ste
filed Hyged off		17. Father's Name (First, Middle, Last)	/			e (First, Middle, Mi	alden Surname)	
21215-0036 ould be filed within 7. Mental Hygiene. marked other than ic event, the Medical	Be	James (Celso 19a. Informant's Name/Relationship (Type, Print)	SAUDY	o. Mailing Address (Stre	MAILY	Lucille	Adam	5
ID 21215-00; should be filed with and Mental Hygiene 77 is marked other ti	ဥ							
		Stacey Savey - 1)4-11	ter 5.	300 Eleanur of Disposition (Name of ce	- Bruske	Way Up	20s Location City	Town State
Ore, of He	- 1	1 X Burial 2 Cremation 3 Removal from	cremate	ory or other place)				
Page nent o	ш	4 Donation 5 Other Specify:	5+. P.	eters Cene	terry 11-	-13-10	Waldorf	Manyland
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 1	21 Sign or of Funeral Service Licensee/		22. Name and Addres	s of Fa ility	0		
o 89 a ii	- 3	reserve /leal		Adams Fu	neral Itoi	e PA, 1	Aguasio 1	8000 Cm
Physician		23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line.	ed the death. Do no	t enter the mode of dying	, such as cardiac	or respiratory arres	st, mock, or heart	Approximate Interval Between Onset and
/Medical -xaminer			ic intoxi	ication				Death
		or condition resulting in death) Due to (or as a co	nsequence of):					
		Sequentially list conditions, b						
	Examiner	if any, leading to immediate Due to (or as a collicause. Enter Underlying Cause	nsequence of):					
78	Ē	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of:					
rted d ansit		d.	,					
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760, ficate be exe g physician g	led	238	.,2/,28a-1 come of pregnancy	per ME g91	.0 12/8/1	O TT	23d. Date of delive	207
876 tifica ng ph	Š	23b. Was decedent pregnant in the		Fetal death 3	Ectopic pregn	ancy	Month	Day Year
Sox 68 Jeath certifi e attending for use as t	icia	Pregnant	at time of death 5					
Box 68 e death certii the attending ed for use as	Physician	1 Yes 2 No 9 V Unknown 9 Unknown						
d by		Part II. Other significant conditions contributing to de	ath but not resulting	in the underlying cause	given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
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Division of Vital Records, P.O. tat or Attending Physician: The law requires that the rather death. al Director: After this certificate has been signed by led in by the finneral director, page 2 should be detach.	Completed					24a. Was ar		autopsy findings available
CO law has e 2 st	핕			<u> </u>		autops; perform	ned? death?	
tal Rec	ខិ	2				1 ✓ Yes 2	No 1 ✓	Yes 2 No
certi	Be	25. Was case referred to medical examiner?			Other Nursi			
Physi r this	은	1 ✓ Yes 2 No	itient 2 FR/Ou				esidence 6 Oth	er:
n of ding Ph		27. Manner of Death 1 Natural 5 Deading Talling Deading	y,Year)		ury at Work? Yes 2 X No	unk	w injury occurred	
ttend death ctor: y the	Ĭ.	2 Accident Investigation		3.30 am				
or A Dire	띏	Suicide O L Could not be		ırm, street, factory, office	building, etc.	28f. Location (St or Town, Sta	reet and Number or F ite Southern	Rural Route Number, City lospical 5300
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Certification:	4 Homicide determined (Specify)	Hospital	L		EleANOR	Brooksway	Upper Marlbor
Hos Fin		29a. Certifier (Check only 1 Certifying Physician: To the best of						
To the Ho within 24 h To the Fu	Medical	one) 2 Medical Examiner: On the basis of e and manner state		nvestigation, in my opinio	n, death occurred	at the time, date a	nd place, and due to	the cause(s)
FFFS	ž	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (M	fonth, Day, Year)
		The mot on	, Lu)	0.0	.M.E. 00M		November 5, 20	010
	ł	30. Name and address of person who completed cause of	f death (Item 23a)	,				
			Medical Exam	iner 111 Penn S	treet, Baltimoi	e, MD 21201		
S	ate		trar's Signature	1				-
Regis		NOV 1 0 2010 Cener	a B. x	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	of Marylar	•	artment of		and M	lental Hy	giene	001	
			State Registrar			Cer	tificate of	Death			Reg. No.	2010	36131
	Physicia	n/	Decedent's Name (First, Middle A 1 1	•						2. Date of De Month Octobe:	ath Day	Year	3. Time of Death
	Medic		4a. Facility Name (if not institution.	onso Rhon			41. O't. Town			Octobe:			9:10 A M
	Examin	er	Wyndham Vaca		•		4b. City, Town, o	Oxon F			4c. (County of Dea Prin	ce George's
	Funeral			6. Sex	7. Age (In yrs. i	ast birthday)	If Under 1 Year	If Under	r 24 Hrs.	8. Date of Birt	th .	g, Bir	thplace (State or Foreign
	Director		213-58-9345	1 🖾 M 2 🗆 F	57	Yrs.	Months Days	Hours	Min.	Dec. 22	, Year 19	52 0	Arkansas
	nd how at	ır	Usual Residence of Decedent 10a, State 10b. County		10c. Cit	ry, Town or Lo	cation					_	10d. Inside City Limits
	larylar 3a-f s ified	Director	DC					Was	hingt	-on			1 X Yes 2 □ No
	or 28		10e. Street and Number				10f. Zip Code	- Mab	111118		10g. Citiz	en of What Co	ountry?
	s 23a	Funeral	2315 Q Street	SE				20020	0		U	nited	States
	death item ner m		11. Marital Status	Armed Fo		S. 13. V	Was Decedent of I f Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White	
36	after al", o	d by	1 ☐ Never Married 2 🛂 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	e	1	☐ Yes 2 🗷 No	Specify:	:		s	necify Af	rican
ဝို	hours natura ical E	Completed	15. Deceder	Year or Da it's Education	ates.	16a. Deced	lent's Usual Occu	pation			16b Kin	Am d of Business	erican Industry
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and	ntal Hed ot	To B	17. Father's Name (First, Middle, L					18. Moth		(First, Middle,			
Maryland 21215-0036	ould b d Me mark matic	•	19a. Informant's Name/Relationsh	Harry Rho	ne	1405 14 7	A.I.I. (O	100		yevely			0.41
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altimore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			Place of Dispo	sition (Name of		D:	ate I		ation - City or	Town, State
<u><u>E</u></u>	Page ment o ant: If ury or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Otato	emetery, crem Fort Li	natory or other pla $oldsymbol{\mathrm{ncoln}}$	ce)	Octob 2010	per 30,	В	rentwoo	od, Maryland
Balt	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service U	ensee			. Name and Addre	ss of Facilit	ty Ste	wart Fi			
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١,			23a. Part Enter the disease, or shock, or heart failure. List o Immediate Cause (Final	complications that on nly one cause on ea	caused the deat ch line.	h. Do not ente	er the mode of dyir	ng, such as	cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
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	ate be executed physiclan and the burial-transit	alE	resulting in death) Last	Due to (or as a consequ	uence of):							
9	death certificate be executed to attending physiclan and ed for use as the burial-transi	edical		d							-	-	
89	certific nding use as	2	IF FEMALE: 23b. Was decedent pregnant		come of <u>pregna</u>						2	3d. Date of de	livery
Box	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🔲 Pregi	Birth 2 🗌 Feta nant at time of o		Ectopic pregnan Other (specify) _	су				Month	Day Year
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rds	equir bould	etec											robably 4 🖾 Unknown
ဝ၁	e law i has b	Completed	*****							24a. Was a autop		prior to death?	topsy findings available completion of cause of
ř	n: The fficate or, pag		25. Was case referred to medical				06.0	lace of Deat	th (Charles	1 \(\text{Yes}	2 🔀 No	1 🗆 Yes	2 🗆 No
VIta	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	Inpatient 2 🗆	ER/Outpatien	Oth	er.		ne 5 🗆 Resid	lence 6	X Other (Spec	Vacation Resorts
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<u>o</u>	tendii leath. Ior: Ai the fu	ifica	2 Accident Investig	ation			M 1 🗆	Yes 2	No				
Division of Vital Records,	or At after of Direct in by	Certificate:	4 Homicide determi	28e. Place	of Injury - At ho ng, etc. <i>(Specify</i>	me, farm, stre	et, factory, office		2	8f. Location (S City or Tow		Number or Rui	ral Route Number,
			29a. Certifier 1 Certifying	Physician: To the be	est of my knowl	edge, death o	ccured at the time	a, date and r	place and	due to the car	ise(s) and	manner as sta	ited
	n 24 h	Medical	(Check 2 L Medical Ex	caminer: On the basi Nurse Practioner: 1	is of examinatior	n and/or invest	igation, in my opini	on, death oc	ccurred at the	he time, date a	nd place, a	and due to the	cause(s) and manner stated.
	Vithi Com	-	29b. Signature and title of certifier				29c. Licens					signed (Month	
			· Clare	eur			D47	654			Octol	oer 28,	2010
V2	15		30. Name and address of person w	•	•	, , , , ,	,	MII D	an	10 17-	L 3 ·	- DC	20010
	Stat		Charlotte K. De 31. Date filed (Month, Day, Year)				Street,	NW K	m GB-	-ro was	ningi	LON, DC	20010
	Registra	_	NOV 0 2 2010	Much	egistrar's Signa	alle							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Donald Lee Reid 28 20ÏO 8:52 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 6538 Appletown Rd. Boonsboro If Under 1 Year If Under 24 Hrs. Social Security Numbe . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours April D2, 1944 Maryland Director 66 215-42-3214 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 6538 Appletown Rd. 21713 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give "natural", White 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Data Processer Education marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvey W. Reid Mildred M. Hutzell and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Page 1 and 2 sl ment of Health a Chris Poffenberger-Daughter 10138 Whitehall Road Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of I Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Boonsboro Cemetery Nov.2,2010 Boonsboro, Maryland Funeral Service Licensee Osborne Pemeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician cancer disease or condition resulting in death) mon ths Medical Due to (or as a consequence of Examiner Humbosis 6 mon The Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 Do the 9 Unknown P.O. I ģ signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown been sig 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy nerform this certificate 1 Yes Yes the Hospital or Attending Physician: I nin 24 hours after death. the Funeral Director; After this certifics npleted filled in by the funeral director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of rtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) October 29, 2010 044996 Lappans Rd Bornsborn MD 21713 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uk 101 31. Date filed (Month, Day, Year)

State

Registrar

NOV O 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20. Robert William Saltzman, Jr. 2010 12:15P™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 22 1 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 . F Hours 51 Yrs. Washington. Director 218-74-3798 1959 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 1621 Bay Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🖪 No Black, White, etc. 1 Never Married 2 🔀 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Robert William Saltzman, Sr. Joanne Rosetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra Kelly Saltzman / Wife 1621 Bay Ridge Rd., Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 10/25/10 Annapolis, Maryland 21. Signat Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ y ear disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of lingury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No signed by the a d be detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed 1 Yes 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 5 Pendina n 24 hours after death.

• Funeral Director: Aft pleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 To the F Conflying Nurse Frantionies To the best of my knowledge, dueth consisted at the line, date and place, and due to the cause(s) and mainer as stated 29b. Signature and title of certifier MD oe and address of person who completed cause of death (Item 23a) (Type, Print) e Terson MD chor 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Taton Stocker		1- For State Certificate of Death Reg. No.	0 3613					
Physician Medical Examine	1/	Decedent's Name (First, Middle, Last) 2. Date of Death Month Pour Year And the Company of the Company	3. Time of Death 1021 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death						
. 1	Ę	Memorial Hospital @ Easton Easton Talbot						
Funeral Director	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	Birthplace (State or Foreign Country) Mayy/and					
kuæ	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	10d. Inside City Limits					
Maryland 28a-f show	٥	MD Talbot St. Michaels	1 Yes 2 No					
Mary r 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What C	ountry?					
vith the		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - Ar	nerican Indian, Black,					
or items 23a or must be notified	Funeral	1 Never Married 2 Married Armed Forces? I Yes 2 No White, etc. Married Armed Forces?						
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2121 2121 Muld be fi marked c event,	90	Terone, Stocker Evon McClease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St	ate Zip Code)					
MD d 2 sho d 2 sho lth and n 27 is		Lavonne Barnett 46 Wayne Drive Dover Delaw 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20d. Location - City						
ore, MC ss 1 and 2 sl of Health ar If item 27 ther trauma								
Baltimore, permit Pages I ar Department of He Important: If ite		4 Donation 5 Other Specify: Chas, thomas Cemetery 11/13/10 St. Mic	haels, MD					
Ball permit Depar Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Fullity Henry 4 Funeral Home, P. A. 510 Washington St. Cambridge,	110 21613					
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and					
/M i l Examiner		Immediate Cause (Final disease a. Bullous emphysema	Death					
Raine of	1	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
i		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
ted Insit	Yall	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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760, cate be physici he buri		AMENDED AMENDED a, 27, per ME g910. 12.13.10 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery and the second seco	rery					
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Records, The law requires figate has been sig, page 2 should be		autopsy prior performed? death	o completion of cause of ?					
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Visio or Atten ther death Director in by the	2	2 Accident Investigation 28e Place of Injury - At home farm street factory office huilding etc. 28f Location (Street and Number of	Rural Route Number City					
Division Septial or Attent hours after death meral Director: y filled in by the Certificati	Suicide of Could not be determined (Specify) or Town, State)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.						
H 2 H 2	Ī	29b. Signature and title of certifier 29c. License number 29d. Date signed (/						
		Carde Hellan O.C.M.E. November 6, 2	010					
	3	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registra	_	31. Date filed (Month, Day, Year) 2010 32 Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Oct Physician/ 2010 7:53 erMan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Street Dorchester ambr If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. 1 2 M 2 □ F Days Months Hours Director Yrs Marylano Usual Residence of Decedent items 23a or 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☑ Yes 2 ☐ No Mbrid 10e. Street and Number 10g. Citizen of What Country? 2/6/3 Funeral USA12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, rces? 2 □ No 1944 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 1 No Specify: Black Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uld be filed within 7 i Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) se wing Chani Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Samp son 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 shou tment of Health and tant: If item 27 is rr bridge. Phas Janes 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Cemetery 8 4 Donation 5 Other (Specify) Veterans Signature of Funeral Service Licensee 22. Name and Address o Facility Home, P.A. Henry Funeral Home, MD 21613 Cambrida 23a Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE Pnysician/ HOMET FAILURE disease or condition MUVI Medical resulting in death) **Examiner** YEMRS CORONARI MISHTSE Sequentially list conditions, Due to (or as a consequence of). ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be eximin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Yes 2 No detached 9 Unknown signed by t. Id be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ LIVER FAILURE 1 🗌 Yes 2 M No 3 Probably 4 Unknown Completed RENA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed prognessive NEMOUTIA 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10058662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FN CARM THE SANGE TEXTS OF THE COUNTY SANGE STO CUNC- 870 CHOSMEME 21613 CAMPRIBLE PRIVE, Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31, 2010 Stebbins Patricia 10:34 p^M Sonya Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 13804 Fareham Lane Upper Marlboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11–04–1956 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Hours Washington, Director 579-70-8427 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examinar most hare a state of the sta 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** 1X Yes 2 ☐ No P.G. Upper Marlboro MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 13804 Fareham Lane 20772 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? ģ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Flementary/Seconday (0-12) Dispatcher Safeway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Stebbins Clarkie Whitaker **Emmett** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cedric S. Whitaker - Brother 13804 Fareham Lane, Upper Marlboro, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛭 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. Nov. 8,2010 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral Home of Funeral Service License 0583 Middleport Lane, White Plains, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform Yes 2 X 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Myanda 2010 raddress of person who completed cause of death (Item 23a) (Type, Print) 7611 S. OSBORUTE
CA R. MIRANDA MD UMW MONTHOW
(Month, Day, Year) 32. Registrary Signature 30. Name and 31. Date filed (Month, Day, Year, State 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thelma M. Smith 2010 \mathbf{P}^{M} 3:40 October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Capitol Heights 1207 Addison Road Apt.# 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 25, 3 9. Birthplace (State or Foreign Funeral Country) Vi<u>rginia</u> 1 □ M 2 🏻 F Months Hours Director 88 Yrs. 577-28-8921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 □ No Capitol Heights Maryland | Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 United States 1207 Addison Road # 132 and 2 should be filed within 72 hours after death Mealth and Mental Hygiene.

tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 X Never Married 2 Married Maryland 21215-0036 African American 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emmet Smith Florence Boston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92037 909 Coast Blvd. # 11 La Jolla, California Judy Sundayo - Niece item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott October 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ArTeriosel enotic Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant a Pregnant at time of death 5 Other (specify) been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? this certificate has funeral director, page 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examinera
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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within 2 To the F

State Registrar 31. Date filed (Month, Day, Year)

only one)

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Octobe Day Year Gerald Vincent Smith 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💹 M 2 🗌 F Months Days Hours Min. Director Takoma Park, MD 220-38-6452 69 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗌 No MD Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 8007 Mandan Road, #203 20770 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Year or Dates.10/58-12/58 Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Salesman Value City Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Joseph Smith Bennie Solon Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Smith / Wife 8007 Mandan Road, #203, Greenbelt, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/1/2010 Alexandria, Virginia . Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Down enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) 2000 Medical Due to (or a a onsequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year the 9 Unknown 9 I Inknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown this certificate has been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Director: After 28d. Describe how injury occurred X Natural iniury vithin 24 hours are. ...

To the Funeral Director: Aftre 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ag 29d. Date signed (Month,

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State Registrar ne and address of person

OmoLara

31. Date filed (Month, Day, Year)

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no completed cause of death (Item 23a) (Type, Print)

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Physicia	an/	Registrar 1. Decedent's Name (First, Middle			ranoate or			2. Date of De		·	3. Time of Death	
Medical Exami				Smith			r Location of Deal		er 2, 2010	Year	1123 hrs	
)		4a. Facility Name (if not institution Prince George's Hosp	4t		Prince	4c. County of Death Prince George's						
Funeral Director		5. Social Security Number 217–06–1966	6. Sex 7.	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year		n.		Cou	hplace (State or Foreigr untry) hington,D.C	
aryland 8a-f show any at once,	tor		ce Georges		, Town or Location						10d. Inside City Limits 1 X Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number 3512 Hubbard	Road; Apt.	302		10f. Zip Code 207 8	35		10g. Citizen of Unit	ed St	•	
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0036 within 72 hours after death with the Maryland jone. ner than "natural?, or items 23a or 28a-f she Medical Examiner must be notified at once		15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4		during mos		ition (Give kind of e. DO NOT use re		16b. Kind of		Company curity	
, MD 21215-0036 and 2 should be filed within 7 ealth and Mental Hygiene. tem 27 is marked other than reaumatic event, the Medical		17. Father's Name (First, Middle, Arthur Ke			, ,		18.Mother's Nam		Maiden Surna			
→ 8 B is if		19a. Informant's Name/Relationsh David Latrel1		band)				or Rural Route Number, City or Town, State, Zip Code) pt.302;Landover, Mary1and 20785				
timore t. Pages l tment of H rtant: If i		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 15, 2010 Riverdale Park Crematory Riverdale, Mary J									Town, State Maryland	
Bal permi Depar Impo injur		21 Signature of Funeral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.200										
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate is Between Ons									Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ✓ Yes 2 No 9 Unki	1 Live birth 4 Pregnant	at time of de	2 Fetal	death 3			23d. Date Month	of delivery D	ay Year	
res that the d signed by the	<u>۾</u>	Part II. Other significant condition	ons contributing to de	eath but not re	esulting in the und	lerlying cause :	given in Part I.			person	he cause of death?	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detact).	: To Be Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 \ No										
ital Redician: The secrificate		25. Was case referred to medical examiner?	Hospital: 1 Inna	utiont 2	ER/Outpatient		of Death (Check	only one)	Basidanas 6	Other:		
of Vii ing Physi After this		1 Yes 2 No 27. Manner of Death	28a. Date of 1	njury	28b. Time of Inju		ry at Work?		Residence 6			
Sion (Attending radeath. Attending rector: Attending by the fur	Certification:	Natural Nat										
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		1 /9a Certifier .										
thin 24	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
F . 3 & . 3	₽	29b. Signature and title of certifier			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) November 3, 2010				
	- 1	000				1						

State 31. Date filed (Month, Day, Year)
Registrar NOV 1 0 2010 DHMH 17 Rev 1/2001 OCME 2006

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SALVIEJO LOUIS N/M/NNOV . 10, 2010 Year 1:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours gMonthy Day 1 Years 9 460-60-9255 TEXXX Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director ST.MARY'S MD. CHARLOTTE HALL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 CHARLOTTE HALL ROAD 20622 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 NARMY
If Yes, Give 1961-64
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify:WHITE "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b Kind of Business Industry (Specify only highest grade completed) WORKERB SHEET METAL MECHANIC Elementary/Seconday (0-12) 12th College (1-4 or 5+) LOCAL 100 of and 2 should be filed with of Health and Mental Hygien of item 27 is marked other the rother traumatic event, the Be 17. Father's Name (First, Middle, Last)
LUIS SALVIEJO 18. Mother's Name *(First, Middle, Maiden Surname)* AUGUSTA TRIANA ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIE SALVIEJO-DAUGHTER P.O.BOX 1254 LA PLATA, MD. 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1:
Department of I
Important: If it
any injury or of j 1 X Burial 2 Cremation 3 Removal from State ST. MARY S CEMETERY 11-16-10 NEWPORT, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Fureral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Renal disease Stage disease or condition Medical resulting in death) Examiner Htherosclenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transif attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular 1 Yes 2 No 3 Probably 4 Unknown page 2 should Dysphagio 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 🗌 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: At 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D.50653 11-10-2010 uy onc Boad Pears 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 1:03 \mathbf{p}^{M} Schmersahl George Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Sunrise Assisted Living Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. Feb. 29, 1920 New Jersey 90 **Director** 142-14-5759 If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 No Frederick Frederick <u>Maryland</u> 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 21702 990 Waterford Drive #306 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Federal Government Microbiologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) permit. Page 1 and 2 should be t Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ew once. မ Millie DeVausnev Francis Schmersahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 Holter Vista Drive, Frederick, Maryland 21702 Barbra Colandreo / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 8. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 2010 Frederick, Maryland 21. Signature Funeral Service License Keeney and Bastord PA Funeral Home 106 E. Church Street, Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ ☐ Unknown page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 15 ease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy this certificate 1 🗌 Yes 1 Yes 2 M Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 2 - No 4 Nursing Home 5 Residence 6 Other (Specify Asst. Living 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reli Ellen -al egistrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar Certificate of Death Reg. No.											
			1. Decedent's Name (First, Middle,	Last)							2. Date of Death Month Day Year 3. Time of			
Physician/ Medical				LLIAM SMITH				Month Day Year November 8 2010			11:55 P ^M			
	Examin		4a. Facility Name (if not institution,	DOUGLAS give street and numbe			4b. City, Town, o	r Location o	f Death		4c. Cou	inty of Deat		
			Frederick Memo	orial Hogni	tal.		Freder	rick			F	rederi	ick	
	Funeral			6. Sex 7.	Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under		8. Date of Bir	th	g, Birt	thplace (State or Foreign	
	Director		220-74-8991	1 ₹M 2 □ F	51	Yrs.	Months Days	Hours	Min.	Dec. 6	, re1958	Mar	Tand	
V."	>		Usual Residence of Decedent											
BEJITIMOFE, IMARY/IGHO Z L Z 13-UUJO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipty or other traumatic event, the Medical Examiner must be notified at once.	sho	ţ	10a. State 10b. County	. 1	1	y, Town or Lo	cation						10d. Inside City Limits	
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4	or Se no	Ō	10e. Street and Number				10f. Zip Code 21702				10g. Citizen of What Country?			
eath with tems 23a er must b		Funeral Director	612 Taney Ave		21/(U.S.A.							
		Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R			cify Yes or No-		14. Race - American Indian,		
o }	or i	by	Never Married 2 Married 1 Yes 1 No If Yes, Give			1 ☐ Yes 2 ☒ No Specify:				riicari, etc.)		Black, White, etc. Specify: White		
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≥ ,	n 27 n 27 ertr		Jack G. Smith,	tather		610	ľaney Ave	enue,	rrec	ierick,	MD 2.	1702		
e,	of ite		20a. Method of Disposition	0	20b. F	Place of Dispo	sition (Name of	ce)		Date		,	Town, State	
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ROX	atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	st 12 months?				leath 3 Ectopic pregnancy ath 5 Other (specify)				Month Day Year		
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> L	this all din	<u>ا</u>	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (s										oify)	
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UIVISION	orter in by	Certificate:												
בַ ב	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 7 Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									ated.		
Ä	Fun Fun eted	Medical	(Check 2 Medical E	xaminer: On the basis	of examination	n and/or inves	tigation, in my opin	ion, death oc	ccurred at	the time, date	and place, and	d due to the	cause(s) and manner stated.	
tho.	ithin orthe	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and may 29b. Signature and title of certifier 29c. License number 29d. Date signed											
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		30. Name and address of person who completed cause of death (Item 23a) (Type, Print).												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 2 OI ORGE 2120 Medical 4a. Facility Name (if not institution, give street and number)
MANDARIN HOSPICE HOUSE 4b. City, Town, or Location of Death Examiner 4c. County of Death
ANNE ARUNDEL HARWOOD . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs 1€M 2□F Months Hours 8 -6 - Day, 8-41)8 WASH, D.C. 578-18-4048 92 Director Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland trent of Health and Mental Hyglene. That If fite ar 27 is marked other than "natural", or items 23a or 28a-f sho lard the transmist event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director PRINCE GEORGES BRANDYWINE MD. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 17205 MAGRUDERS FERRY ROAD 20613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. orces? 2 □ No ARMY ve WWII 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 M Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) FEDERAL POLICE OFFICER Elementary/Seconday (0-12) College (1-4 or 5+) U.S.GOVT. 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
SALLIE MORROW ည WALLACE SOUDERS 19a. Informant's Name/Relationship (*Type, Print*) GEORGIA FURBUSH-DAUGHTER permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum ress Street and Number of Bural Route Number City of Town. State Zin Code MAGRUDERS FERRY RD. BRANDYWINE, MD. 20613 20a. Method of Disposition 20c. Location - City or Town, State CHELTENHAM, MD. 20b. Place of Disposition (Name of -12-10 MD TERANS THE CEM. tX Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Ineral Service Lice Name and Address of Facility AL SERVICE, P.A. A PLATA, MARYLAND 20646, P.A. M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ONAR Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown s been signed by the should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρΛ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has l ; page 2 s autopsy perforn 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes funeral director, Be 26. Place of Death (Check only one) Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) MANDEN မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of HOUSE Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes death. 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certiflei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) B 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State NOV 17 Registrar

DHMH 17 Rev 7/2009

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8:40 PM ynthia, E. Sidne 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Cit Shock Trauma Center 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington, DC **Funeral** 1 □ M 2 🛣 F Days Hours /10nth, Day, Year) 131/1948 Director Yrs. 578-66-0899 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If fine 77 is marked other than "nature"...

any injury or other trained. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Riverdale MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6083 64th Avenue 20737 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Conference Coordinator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ George Perrin <u>Ethel Staley</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trenessa Sidney - Daughter 6083 64th Avenue Riverdale, Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/16/2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Mont 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or gomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Necrotizing fascintis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner days Sequentially list conditions if any reading to it. Perforated Examine Dire to for a consequence of if any leading to in medi-cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No signed by the atte Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diverticulasis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has page 2 autopsy death? this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? ဂ္ 1 🗆 Yes 2 📑 No Other: ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending s after death. Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) thin 24 hours the Funeral Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d, Date signed (Month, Day Year) atre AU4176435N18922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadran Katic South Greene Baltimore

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Ye

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 10/28/2010 AACO HEALIH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Rebecca I. Thompson 19 201 10:23 AM DCTOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Future Care Chesapeake Arnold If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Sept 4 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 931 Days Hours Maryland 79 218-28-3816 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Exp. inter must be realled at Shady Side 1 ☐Yes 2X No Maryland Anne Arundel filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20764 6113 Shady Side Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/IndustryNationwide 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nationwidw i 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Server 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Foote James Donnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur once. 1215 Shesley Rd. Edgewater, Md. 21037 Faye Curtis(Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran | 10-26-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) M Marne Recorded of Secilisions Mortuary, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 **Physician** disease or condition resulting in death) CEREBROVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No DISORDER 3 Probably 4 Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral of the funeral completely filled in by the funeral completely filled in the funeral completely fil 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sectifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 19,2010 DS MX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October ^{Day} 20 2010 Edward Tucker 4:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death South River Health & Rehab Edgewater Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day 1 Hours Year) 9<u>33</u> Director 213-30-9687 77 Maryland Jan Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
 Intent of Health and Alenter Hyglene.
 Intent if I flea and And Anderfor than "natural", or items 23a or 28a-f sho lant if I flea by an adverted than "natural", or items 23a or 28a-f sho inty or other traumatic event, the Medical Examiner must be notified at inty or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel **Annapolis** 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21409 USA Shot Town Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Black d Mental Hygiene. marked other than "natura matic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Detailer Automobile's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Oliver Tucker Sr Cora Stansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver Tucker(Brother) Box 103 Benning Rd. Galesville, Md. 20765 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 10-22-10 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Baseof Scilit Sons Mortuary, Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Javr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Atherosclerotic disease or condition resulting in death) Cardio Vascular diseas Medical Due to (or as a consequence of): Examiner Hypertensi' Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or iinjury signed by the attending physician and detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by melli 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy Peripheral performed? Yes 2 3 N vascular 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at > Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) yan-c D50653

State Registrar

DHMH 17 Rev 7/2009

Churchton

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

851

31. Date filed (Month, Day, Year)

GYAN C.

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SURANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 8, Physician/ [□]2<u>010</u> Clarence Edward Teter 8:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 18208 Hickory Mountain Lane Oldtown Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthiplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 □ F Hours Min. Oct **Director** 212-32-8233 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic pure". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Oldtown Allegany 1 ☐xYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 18208 Hickory Mountain Lane 21555 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 ☐ No Specify: Completed Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator Teter Excavating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Teter ·Mary (Barnes) Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18208 Hickory Mountain Lane Oldtown MC Wanda Teter wife Oldtown MD 21555 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 11/11/2010 Oldtown Catholic Cemetery MD Oldtown 4 ☐ Donation 5 ☐ Other (Specify) Ignature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ 2 he disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on. Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 100 Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 3 🗔 Cpatifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 29d. Date signed (Month, Day, Year) NOV P, 2010 00033280 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p CLIMBERLAND, MD 21503 KENT 31. Date filed (Month, Day, 32. Regist ar's Signature State

DHMH 17 Rev 7/2009

Registrar

Mr.

			For State Registrar	State of Mary	land / Dep	artme	nt of H			-	giene		3611.8	
			Hegistrar Decedent's Name (First, Middle, L.)	ast)		runca	ic or i	Jeani	2	. Date of De	R eg. Ne.	010	3. Time of Death	
	Physic	ian	Robert Eugene		Cr.					Month NOV •	Day	2010		
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	Euporol				yrs. last birthday		or 1 Year	If Under 24	4 Hrs 8	. Date of Birt		Baltimore 9. Birthplace (State or Foreign Country)		
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	er de	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dec	edent of Hi ecify Cuba	spanic Origi n, Mexican, i	n? (Specif Puerto Ric	y Yes or No can, etc.)	. 1	 Race - Amer Black, White 		
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Maryland	2 shou and N is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Addres	s (Street a	and Number	or Rural F	Route Numbe	r, City or	Town, State, Z	ip Code)	
	iges 1 and 2 should be filled within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-1 show or other treumetic event, the Wedfeal Examinar in ust be notified at		Diane T. McCar	ty/Daughte:	155	E. I	Iigh	St.,	New	7 Free	edom	, PA 1	7349	
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	To t with	Σ	29b. Signature/and/title of certifier	100	p 4	29	c. License	number				signed (Month	, Day, Year)	
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ų.			30. Name and address of person who MANUC 5. IC.	completed cause of death RPLAY MD	(Item 23a) (Type,	Print)	Isnk	ld	o A	10MC	TON	MO:	21111	
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MH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	Type or Print in E State of Maryland						-	
		1 - For State Registrar	State of Waryland	•	ertificate of L		•	Reg. No	2010	36149
Physicia Medic		1. Decedent's Name (First, Middle, Last) Elizabeth Aileen					2. Date of Dea Month Novemb	Da	3 20 1 0	3. Time of Death 9:47 A M
Examin Funeral Director		4a. Facility Name (if not institution, give s 11 West Baltimore 5. Social Security Number 6. Security Number 6. Security Number 6.	St. X 7. Age (In yrs. la	st birthday) Yrs.	4b. City, Town, of Hagerst If Under 1 Year Months Days	r Location of Death OWN If Under 24 Hrs. Hours Min.	·	h 4d	County of Death Solution Ashington 9. Birth	n County place (State or Foreign ecticut
	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Washingto		, Town or L			1000. 23			10d. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 11 West Baltimor	e St.		10f. Zip Code 21740			10g. C		
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1 and 2 shout Health and Item 27 is nother traun		19a. Informant's Name/Relationship (Typ. David H. Tuell-hu 20a. Method of Disposition	isband 206. PI	11 We lace of Disp	ing Address (Street a est Balti osition (Name of	more St.		own		4Ô
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Physician/ Medical Examiner		23a. Part 1. Enter the disease, of compleshock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	idations that caused the death e cause on each line. a	Do not en	331 Easte ter the mode of dyin	g, such as cardiac		est,	erstown,	MD 21742 Approximate Interval Between Onset and Death
ath certificate be executed attending physician and for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	Ideath 3	☐ Ectopic pregnand ☐ Other (specify)	су			23d. Date of delive	ery Day Year
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y Physician er this certifi eral director	e: To Be	27, Manne of Death		28b. Time o	of 28c. Injury	4	1/		6 Other (Specify	γ)
al or Attending s after death. Il Director: Afte ed in by the fun	l Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year) 28e. Place of Injury - At hor building, etc. (Specify)	injury ne, farm, st		Yes 2 □ No	28f. Location (S City or Tow		nd Number or Rural	Route Number,
o the Hospit ithin 24 hour the Funera	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ler: On the best of examination Practioner: To the best of my	and/or inves	stigation, in my opinio	on, death occurred a e time, date and pla	t the time, date ance, and due to the	nd place cause(e, and due to the car	use(s) and manner stated ated.
+/		Jung &	empled cause of death (Item	23a) (Type,	Doo	57285	-		1 - 1	ê\ O
√-○ Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Waln	# +2 tu	102 Har	jerstann	N	4715 di	0
Registra	ar	MOV 0 5 20	HH. / A.	A	6 -0 1					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 26 per med cert G909 12/1/10 ak
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0 1311 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death (sever 11000 Security Number 7. Age (In yrs. last birthday) Year If Under 24 I 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 Months Days Hours Min. Country)California 067T9 PY956 566-19-1444 54 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 United States 1476 Lowell Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Mexican If Yes, Give Year or Dates 3 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Representative Distributing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Sagarnaga Ruben Verdugo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1476 Lowell Court, Crofton, Maryland 21114 Dawn Hegeman Verdugo/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 10/27/2010 Edgewater, Maryland 4 Donation 5 Other (Specify) . Signature of Funor Service I 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner a consequence of and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burialattending physician Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a 1 ∐ Yes 2 L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe death? this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiler?
1 In Yes 2 INo Division of Vital funeral director, Be 26. Place of Death (Check only one) Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending work Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

be basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying P vsician: To Medical Examiner: On only one Gertifying Nurse Prac over. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 100 2010 ho completed cause of death (Item 23a) (Type, Print

State

Registrar

31. Date filed (Month, Day, Year)

32. Rec

OCT 2 6 2010

		-	•				es Are Legible) .	
		For State Registrar	State of Maryl		ment of Health cate of Death	and Mental H	ygiene Reg. No. 2 A 1 (26151	
		Decedent's Name (First, Middle, Last)				2. Date of D	Death	3. Time of Death	
iciar edica		Jonathan Carl Vogel				Octobe	Day Year		
mine		4a. Facility Name (if not institution, give stree		11 -	. City, Town, or Location		4c. County of Dea		
5		5 hady Grove Ac 5. Social Security Number 6, Sex	dventist	rs, last birthday) If	Under 1 Year I if Under		monts		
ral tor			1 2 🗆 F		onths Days Hours			irthplace (State or Foreign ountry) IL	
		Usual Residence of Decedent							
	횽	10a. State 10b. County MD Mon toome		. City, Town or Location Bethesda	n			10d. Inside City Limits	
	Ē	10e, Street and Number	,,,		0f. Zip Code		10. 077 6747 6	1 🗆 Yes 2 🎦 No	
	Funeral Director	8417 Westmont Terrace			20817		10g. Citizen of What C	ountry?	
	<u>.</u>	11. Marital Status 12.	Was Decedent Ever in		Decedent of Hispanic C	Origin? (Specify Yes or No		erican Indian,	
	ا≲	1 ☐ Never Married 2 🕱 Married	Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give		s, specify Cuban, Mexic Yes 2 X No Specif		Black, Wh Specify: Wh		
	ğ	3 L Widowed 4 L Divorced	Year or Dates.		· -	····	Specify: ***	100	
,	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give kind	s Usual Occupation of work done during mo OT use retired)	ost of working	16b. Kind of Busines	s Industry	
		Elementary/Seconday (0-12)	Coilege (1-4 or 5+) 5+		ch Physician		Federal G	overnment	
		17. Father's Name (First, Middle, Last)				ther's Name (First, Middl			
	잍	Martin E. Vogel			E1	lvira W. Schne	ider		
	2	19a. Informant's Name/Relationship (Type, F Elizabeth Falloon/Wife	Print)			ber or Rural Route Numi ce, Bethesda,	ber, City or Town, State, Z MD 20817	Zip Code)	
		20a. Method of Disposition	20	b. Place of Dispositio	n (Name of	Date	20c. Location - City of	or Town. State	
		1 ☐ Burial 2 😾 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	cemetery, cremato tropolitan (Oct. 30, 2010	Alexandria,	·	
once	- 1	21. Signature of Funeral Service Licensee		22. Na	me and Address of Fac		<u> </u>		
9		Janas S (Jeobly	500	University Bl	lvd. W., Silve	e Inc. r Spring, MD 2	0901	
		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca						Approximate Interval Between	
an/ cal		Immediate Cause (Final disease or condition resulting in death)	Metast		enal Cell	Cancer	,	Onset and Death 10 ms nums	
ner			Due to (or as a con-	sequence ot):					
	in e	Sequentially list conditions, b. = liy leading to immediate cause. Enter Underlying	Due to (or as a con-	signence off:					
Ы	Examiner	Cause (Disease or iinjury that initiated events c. =							
		resulting in death) Last	Due to (or as a con-	sequence of):				1	
	eg	d						<u> </u>	
- 1	[≥		If yes, outcome of pre		topic pregnancy		23d. Date of d	elivery	
	sicia	Month	Day Year						
		9 ☐ Unknown Part II. Other significant conditions contrib	I tobacco use contribute	to the serves of death?					
	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1								
	ete			utopsy findings available					
,	팂					aut	topsy prior to formed? death?	completion of cause of	
		25. Was case referred to medical			26. Place of De		s 2 X No 1 1 Y	es 2 🗆 No	
		examiner? 1 Yes 2 No Hosp	ital: 1 X Inpatient 2	P ☐ ER/Outpatient 3	DOA Other: 4 🗌	Nursing Home 5 🗆 Re	sidence 6 Other (Spe	ecify)	
	ate:	1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yea		28c. Injury at work?		how injury occurred		
	≗	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	at ho <i>m</i> e, far <i>m</i> , street, f	√ 1 ☐ Yes 2 [_	(Street and Number or R	ural Route Number	
	Medical Certificate:	4 Homicide determined	building, etc. (Spe				own, State)	o.aioato italiibo,	
	dica	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner:						tated.	
.		only one) 3 Certifying Nurse Pr			occurred at the time, da	ate and place, and due to	the cause(s) and manner a	s stated.	
2		29b. Signature and title of certifier Poseph m. H	egeste m	0	29c. License number		29d. Date signed (Mon		
		70 cegar 1	-//~		D3240		October 3	ال ال عن ال	

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH M. Haggerty MD 9701 Medical Cyr Dr. Rockv. He. MD

31. Date filed (Month, Day, Year)

NOV 01 2010

Registrar's Signeture

J. Facel

J

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ [™]Nov 5, 2010 VanMeter Sr. 11:00 AM Roger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15810 Cresap Mill Road SE Oldtown Allegany Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** 1 🖳 M 2 🗆 Months Hours Feb 2 . Year) 9<u>50</u> **Director** 217-54-7028 60 Usual Residence of Decedent and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Oldtown 1 Xes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21555 USA 15810 Cresap Mill Road SE 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Vietn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Vietnam Specify: 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ATK operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emory C. VanMeter Thelma (Gordon) VanMeter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 15810 Cresap Mill Road Oldtown MD 21555 Wife Janet VanMeter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date sunset Memorial Park 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/9/2010 MD Cumberland 4 Donation 5 Other (Specify) of Funeral strvice Licenses 21. Si natur 22. Name and Address of Ferilly Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between CIRRITOSIS Onset and Death Immediate Cause (Final cortoric LIVER Physician/ MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions ner cause (Disease or linjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contact. the attending physician and hed for use as the burial-transit Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No ours after death. eral Director: After this certificate has been signed by the s filled in by the funeral director, page 2 should be detached i 9 Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗓 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 뎯 1 ☐ Yes 2 ☑ No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗓 🖒 🕳 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death packer and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature of person who completed cause of death (Item 23a) (Type, Print) 912 SETON DRIVE CHURERLAND MD 21502 OVERIA IR, MD 320 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DK

DHMH 17 Rev 7/2009

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Brandon Allan Weimer	State of Maryland / Department of Health and Mental Hygiene	20

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		1- For State Registrar	•		Certifica	ate of L	Death		,,	Re	eg. No.	, ,	0 0010
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middl								Date of Deat Month October 24		,	3. Time of Death 1655 hrs
viedicai Examii	ilei	Brandon Alan We 4a. Facility Name (if not institution		umber)		4b.	City, Town, or	Location o		October 24	4, 2010 4c. County c	f Death	
		Memorial Hospital					Easton				Talb⊡t		
Funeral	Ī	5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under 1 Year Months Days		1 40		th (MM/DD/YYYY)	g. Birt Foreig	nplace (State or
Director		215-47-4560	1 M 2 F		14	14 Yrs. Months Days Hours Min. 4/21/1996							intry) MD
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c	City, Town	or Location	1						10d. Inside City Limits
<u>*</u> .	L	MD Care	oline				Preston						1 Yes 2 XXNo
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with the Maryland ns 23a or 28a-f sho be notified at once.		5780 Nagel Rd.					21	655			USA	Ā	
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5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once			1 Yes	2 X X	No	1□ v	es 2 XX No	enecify:			Specify:		ite
urs aft tural'	g P	15. Decedent's Education (Spe	or Dates:			Decedent's	Usual Dccupati	ion (Give k			16b. Kind of Bus		
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most	t of working life,	DO NOT	use retired))			:
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	dwo	8 17. Father's Name (First, Middle,	Last			S	tudent	10 1 404 0 00	la Nama /Fi	ent & Entello &	Educa	tio	n j
	Be C	Mitchell Weime							,	Spring			
2121 ould be fi Mental marked ic event,		19a. Informant's Name/Relations			196	. Mailing A	ddress (Street				ber, City or Towr	n, State,	Zip Code)
MD and 2 shoulth and n 27 is aumatic		Mitchell Weime	er Fatl				agel Rd			n, MD			
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental rant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 1 XX Burial 2 Cremation	n 3 Removal f	1		of Disposition ory or other	on (Name of cen place)	netery,	D	ate	20c. Location -	City or	Fown, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ļ	4 Donation 5 Other Sp			Hille:		Memoria		10/29	9/2010	Annapo	lis	, MD
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Euneral Service	Licensee				ne and Address		нагае	esty F	uneral H	lome	, P.A.
Physician	\dashv	23a. Part I. Enter the disease, or		caused the	death. Do no		Annapo mode of dying,				11s, MD est, shock, or hea		Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	A b										Between Onset and Death
Adminier	- 1	or condition resulting in death)	Due to (or as	a conseque	nce of):								
	틸	Sequentially list conditions, if any, leading to immediate	b. Hanging Due to (or as	a conseque	nce of):								
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ficate be executed g physician and the burial - transit	Physician/Medical	UNPENDED	AMENDED	· <u>-</u>									
760, ficate b	We	IF FEMALE: 23b. Was decedent pregnant in th		outcome of				7			23d. Date of		Year-
Box 68 e death certif	ciar	past 12 months?	I I LIVE	nant at time			death 3 (Ectopic	pregnancy	<i>(</i>	Month	D	ay Year
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/ital ysician	o Be	examiner?	I loopitals	Inpatient	2 ✓ ER/Oι	utpatient 3		O41.	Nursing H		Residence 6	Other:	
of Vit ling Physic After this (-	27. Manner of Death	28a. Date	of Injury h Day Year) 2010		Time of Inju	ry 28c. Injur	y at Work?			now injury occurre	ed	
ttendi death. tfor: /	gi	Natural 5 Pend 2 Accident Invest	stigation		0000			'es 2 🗸	No	bject nang	ged Hillisell		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	deter	a not be			rm, street, t	factory, office bu	uilding, etc		or Town, St			al Route Number, City
Lospit: 4 hour 7unera	- 1	4 Homicide	hysician: To the be	Reside		th occurred	t at the time, da	te and pla					d.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam		of examinat									
F % F 8	ž	29b. Signature and title of certifie	er				29c. License			-	29d. Date signe		
		my as,	NP				O.C.N	И.E.			October 26	2010	
747		30. Name and address of person Ling Li, MD Assista	who completed cau nt Medical Exa			Street	Baltimore, N	MD 2120	01		-		. ———
Sta	ite	31. Date filed (Month, Day, Year)		e sistrar's Si				2120	· ·				
Regist		OCT 2 8	3 2010	enua.	, A	par	KN						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#20C per FH State of Mar State State Registrar 10/28/2010 AACO HEALTH CMH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Walker James F. 2010 3:33A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 2004 E. Chase St. N/A 8. Date of Birth (Month, Day, Y Apr 26 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year 1924 1 M 2 F Virginia 227-20-6984 86 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 2004 E. Chase St. 21213 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", Completed 3X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School 0 0 Janitor Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of 2 1 and 2 should be f Health and Ments item 27 is marked other traumatic e Graham Walker Blanche Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Walker(Son) 1643 Elkwood Ct. Annapolis, Md. 21409 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b Flest pon Disposition (Gamerotre 20c. Location - City or Town State 1

Burial 2 □ Cremation 3 □ Removal from State 10-29-10 Lawrence, Church Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Windame Accessed RecilitSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 coseMOO48 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic gastric cancer Physician/ 20 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin that the death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 4 Pregnant g Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ high blood pressure or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Coronary artery disease 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? insthicience this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide injury 5 Pending 2 No Investigation s after deatl Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital hours a Medical rthying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Hopkins Harita 1 1650 Orleans St Balhmore MD 21231 Dan Laheru, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 29. Physician/ 2010 Wade Carl Joseph 4:40 Am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1XX M 2 □ F Months Days Hours Feb 24, 1946 Washington DC 217 44 2894 Yrs. Director 64 Usual Residence of Decedent 28a-f show 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 TYNO Maryland Charles Waldorf 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12810 LaPlata Road traumatic event, the Medical Examiner must 20602 United States 12. Was Decedent Ever in U.S. Armed Forces? 140 Yes 2 \(\subseteq \text{No} \) 1965— 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 ☐ No Specify: Completed 3 - Widowed 4 X Divorced 1968 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John H. Wade Dorothy E. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Wade (Sister) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 3534 Norwood Court, Waldorf, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Nov 5, 2010 Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria ature of Funeral Service Licensee MOISS Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ CIRRHOSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 L Yes 2 No ed by the a detached f g Unknown P.O. been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTENSION FAILURE Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Hospital or Attending Physician: The certificate Yes 2 X No Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 \square Pending Accident Investigation To the Hospital or Attence within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier ATTENDING PHYSICING D52900 10-30-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLENN DATE MD 20769 12150 ANNAPOLIS ROAD HZOS MOMOH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 1 Some Registrar

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours a To the within 2.

DHMH 17 Rev 1/2001 3 21

Registrar

29a. Certifier

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) November 10, 2010

Please Type or Print in Black Indelible in Firshing Alk Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 11, Year 010 Dorothy Mae Winpigler 6:45AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, Days 1 M 2 XF Country) Maryland Director 219-12-1981 Nov. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Linden Blvd. 21769 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Completed 3 XWidowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 2010 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 72 and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. <u>dministrative Secretary IUS Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Shipley NOVEMBER Miriam Ziegler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Bottcher (niece) 16441 JM Pearce Rd., Monkton, MD, 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crem. 11/12/2010 Smithsburg, 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Keeney & Basford P.A. Funeral 106 F. Church, Frederick, MD, Ryan Geiger/DVR M01612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e 2 line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death nome disease or condition resulting in death) 40 Medical Due to (or as a consequence of) Examiner 2VD3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): ate has been signed by the attending physician apage 2 should be detached for use as the burial. Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate has performed? Yes 2 No 1 Tyes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2× No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending injury ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD WRIGHT, ERNESTINE, M.D. TIMONIUM MD 21093 31. Date filed (Month, Day, Year) 32. Registar's Signature State NOV 1 Registrar DHMH 17 Rev 7/2009

Dro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Theodore WOLFORD, JR. October 31, 2010 0039а.м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-42-3622 1 **x** M 2 □ F Months Davs Hours Director 67 Mary Land 1943 Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Funkstown Maryland Washington or 28a-f Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21734 122 Stouffer Avenue items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No o Black, White, etc. þ 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white If Yes, Give marked other than "natural", Specify 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) medical record Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. consultant consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>م</u> John T. Wolford, Mary L. Brennan 1 and 2 shou of Health and item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Wolford - mother 122 Stouffer Avenue, P.O. Box 327, Funkstown, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date permit. Page 1 and Department of Important; If its cemetery, crematory or other placel any injury or 1 Burial 2 X Cremation 3 Removal from State October 3 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Signature of Funeral Service Licens 22. Name and Address of Facility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 2174p 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of wind, such as cardiac or respiratory arrest, shock, or heart failure. List only one constraints. Immediate Cause (Final Peath Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: s, of ome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not esulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the duse of death? þ 1 Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate has been siy completed filled in by the funeral director, page 2 should to Completed 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No 25. Was case referred o medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2, No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner de th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check nly one) the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10-27-201 Olanrewaju Yussuf 3:40 р Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 Hours (Month, Day, Year) 2-10-1960 50 217-29-5271 Nigeria Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Prince Geo. Bowie 1 X Yes 2 No 10e. Street and Number ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 2106 Woodville Ln. 20721 USA 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc ð 1

✓ Never Married 2

✓ Married Maryland 21215-0036 I Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Physician Healthcare/Doctor Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abdul Raheem Yussuf Sherifat Emi 19a. Informant's Name/Relationship (Type, Print) cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abdul Raheem Yussuf-11605 Duckettown Rd, Laurel, Md. 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place)
Maryland National 10-29-10 1 X Burial 2 Cremation 3 Removal from State Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility411Kennedy St, N.W Signature of Funeral Service Licensee Universal Mortuary Inc, Wash, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ COMPLIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Saguentially list exactitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown been signed by the s should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐ Yes 2 🔀 No 2 X No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2**X** No Hospital: Other: မ 1 Inpatient 2 ER Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending 24 hours after death. Funeral Director; A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature ar certifie ٩ 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Horace Medical Milton Arnold 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 09 22 **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min. 216-56-4933 Director Country) Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d, Inside City Limits NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1214 Ramblewood Road 21239 U.S.A. items ; 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 010 Black, White, etc. þ 1 Never Married 2 X Married "natural", 1 Yes 2 X No Specify. Specify: Black 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour popartment of health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Athletic Director Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Hubert O. Arnold Sr. Lilie E. Baskerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 Ramblewood Road, Baltimore, Md Debra A. Arnold-Wife 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Memorial Park 11/9/2010 Woodlawn, Md Sign 22. Name and Address of Facility
March F/H West
4300 Wabash Av Autolo df Funeral Service Licenses Ave, Baltimore, Md 23a. Par 1. Enter the lisease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart a lure. List only one cause on each line. Interval Between Onset and Death Immediale Cause (Final Physician/ disease or condition resulting in death) Intracerebral Hemo-Medical Due to (or as a consequence of): Examiner rombocyto Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi Chemothe that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year 1 ☐ Yes 2 L 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Corcinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 sl 24a. Was an autopsy 1 Yes 2 No Yes 2 X No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No ည 1 Inpatient 2 FR Outpatient 3 IDOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 8b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work Accident
Suicide Investigation 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b, Signature and title of certifie M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSERH M.D. 5601 LOCH PAVEN BLVD BALTIMORE, MD 21239

DHMH 17 Rev 7/2009

State Registrar Registrar's Signa

10-08444 Anthony Ash Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

antinony Asir		1- For State Registrar	State of Mary	•	rtificate of L		entai Hygiene	2 0 Reg. No.	10 3616		
Physic		Decedent's Name (First, Name)				· ·	2. Date of Month	Death	3. Time of Death		
Medical Exam	iner	Anthony As 4a. Facility Name (if not insti		umber)		City, Town, or Location		Day Yea 1ber 4, 2010	1628 nrs		
		35 Alma Avenue	, g			_aurel	or or beauti	Howard	n Beaut		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)		nder 24Hrs. 8. Date o	f Birth (MM/DD/YYYY) 9. Birthplace (State or Foreig Country)			
Director		213-38-363		72	2 Yrs.	- Days Tio		12, 1938	12, 1938 Michigan		
any		Usual Residence of Deceder 10a. State 10b. Cou		10c. City	, Town or Location				10d. Inside City Limits		
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after d	by Fi		Divorced If Yes, Give Ye or Dates:	^{ar} '56-60	1 Y	es 2 X No spec	ify:	Specify:	white		
5-0036 led within 72 hours afte Hygiene, other than "natural", the Medical Examiner		15. Decedent's Education (Elementary/Secondary (0-		de completed)		Usual Occupation (Gi of working life. DO N		16b. Kind of Bu	siness/Industry		
336 thin 72 re. than	Completed	12	Ollege (ŕ	rena	irman		rofrido	ration/AC		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To Be	Eugene Lesse 19a. Informant's Name/Relat			10h Mailing A		ileen Grace		0111		
nore, MD 21215-00 ages I and 2 should be filed wir in of Health and Mental Hygien it: If item 27 is marked other other traumatic event, the LM.	F	Judith Mille					Each Road S				
re, rand F. Healt F. Healt		20a. Method of Disposition	ation 3 Removal for		Place of Dispositio crematory or other	n (Name of cemetery,	Date		City or Town, State		
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Baltimore, permit. Pages 1 a Department of He Important: If ite	Ш	21. S in ture of Funeral r	rice Licensee	Director	r Stat	e and Address of Fac e Anatomy	Board 655	W. Baltim	ore Street		
Physician	8	23a. Part I. Enter the die	e, or lem dications that of	aused the death	IBa1t	imore MD	21201				
/Medical		f ure. List only one ca	use on each line.		ascular Disea				Between Onset and Death		
Xammer		or condition resulting in deat		a consequence o	of):						
	ē	Sequentially list conditions, if any, leading to immediate		a consequence o	of):						
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8760, ificate be ng physic is the bur	Σ	IF FEMALE: 23b. Was decedent pregnant		outcome of preg	,	death 3 Ecto	ppic pregnancy	23d. Date of Month	delivery Day Year		
Box 687 e death certific the attending p	sicia	past 12 months? 1 Yes 2 No 9	4 Pregr	nant at time of de	nath =	(Specify)	programoy	- WOTOT	Day Toal		
that the des	Physician/	Part II. Other significant co	a		esulting in the und	erlying cause given in	Part I 23e D	id tobacco use contril	bute to the cause of death?		
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of Vital Recing Physician: The After this certificate funeral director, page	Bec	25. Was case referred to me examiner?					ith (Check only one)				
Division of Vital tal or Attending Physician: 1s after death. al Director: After this certiled in by the funeral directors	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatient 3 28b. Time of Injur			Residence 6			
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ViSion Atte	ifica		nvestigation 28e. Plac	ce of Injury - At he	ome, farm, street, f	actory, office building,			er or Rural Route Number, City		
Di spital nours a neral I	Certification:	4 Homicide	letermined (Specify)				or low	n, State)	h h		
Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be executed within 24 bours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi			g Physician: To the be Examiner:On the basis								
To t with To t	Medical	29b 810 nature and title of ce	and manner s	stated.		29c. License numb			ed (Month, Day, Year)		
		(a. [1	111	//		O.C.M.E.		November 6			
		30. Name and a dress of per			·						
	U 10	Zabiullah Ali, M.D.	Assistant Medic	cal Examiner		Street, Baltimore	, MD 21201				
S Regis	tate	31. Date filed (Month, Day, Ye	7110	eyisuai s olghal	Market						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 14, 2010

4c. County of Death Robert Blevins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hospital Maryland Harfor Have de bruce 5. Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□ F 76 215-30-7093 Director VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maritical Exemption in must be investigated. MD CECIL PORT DEPOSIT Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 THOMAS STONE COURT 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1952-55 1 ☐Yes 2€ No Specify þ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICAL MANAGER SEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN BLEVINS MARGIE TOBLER) ပ 19a. Informant's Name/Relationship (Type. Print)
JAMES BLEVINS/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,9\,0\,4$ 37 THOMAS STONE COURT PORT DEPOSIT, MD 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH | 11-18-2010 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner oronani Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 ☐ Yes 2 **V** o 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 V 2 🗆 No 1 ☐ Yes 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) November 15, 2010 w, MD; 501 S. Union Avenue; Harvede Grave, Maryland 21078 State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16,2010 Physician/ November .Tr. T. Bush William Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel 112 Glenlea Drive Glen Burnie 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number . Age (In yrs. last birthday) Sex 1 AM 2 AF Days Sept. 21 **Funeral** Mary Land ,1947 214-46-1207 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County shov 10a. State Director notified Anne Arundel Co. Glen Burnie 28a-f Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ems 23a or 2 by Funeral 112 Glenlea Drive 21060 United States Was Deceden Armed Forces? Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Warehouseman 12 vrs. 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Robinson 0 Dorothy Thomas Bush, Sr. William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Maryland <u>Glenlea Drive</u> Mrs. Deborah A. Bush 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Glen Burnie, MD Glen Haven Mem. Park 11/20/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Sep Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Osset and Death Colon Cancer Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Completed by Physician/Medical Box 68760 should be detached Q. Be

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, within 24 hours after deatl

To the Funeral Director:
completed filled in by the

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Certificate:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of a 9 Unknown	Il death 3 🔲 Ectop						nte of del	Day	Year
Part II. Other significant conditions	conti	ributing to death but not res	ulting in the underlying	ng caus	e given in Part I.		23e. Did tobacco				
						- A	1 🗌 Yes	2X No	3 🗌 P	robably	4 Unknown
							24a. Was an autopsy performed?		prior to death?	topsy find completic	dings available on of cause of
25. Was case referred to medical	$\overline{}$			2	6. Place of Death (Che	ck only					
examiner?	Но	spital:	ER/Outpatient 3	DOA	Other:	lome	5 Residence	6 🗆 Oth	ner (Spec	ify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c.	Injury at work? 1 □ Yes 2 □ No	_	Describe how inj				
3 Suicide 6 Could no 4 Homicide determin	t be	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, fac	tory, of	fice	28f.	Location (Street City or Town, Sta	and Numb ite)	per or Ru	ral Route	Number,
		ian: To the best of my know er: On the basis of examination Practioner: To the best of m									and manner state
only one) 3 L Certifying N 29b. Signature and title of certifier		RECTOR,			cense number		29d.	Date signe	ed (Mont	n, Day, Ye 201	6 6

when

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Be House, MD

State

Registrar

within 2

MEDICAL ONCOLOGY

Hopurs 32. Registrar's Signature

E-ARLAND.

30. Name and address of person who completed cause of death (Item 23

JOHNS

POSS DONEHOWER, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 8:284 M **Physician** November 2010 /Medical 4c. County of Death Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Feb 9 9. Birthplace (State or Foreign 5. Social Security Number Hours **Funeral** ^{Year)} 47 291-80-0721 Irań Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Morth XX Yes 2 No Director C arolina Mecklenburg Matthews 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.S.A. 28105 241 Minden Lane Funeral and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Married 1 Yes 2 If Yes, Give Year or Dates: Specify: Middle Eastern 1 ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

is marked other than Engineer Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mahdari Mehdi Bonakdar Esmat ၉ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10724 Old Wayside Road Charlotte NC 28277 19a. Informant's Name/Relationship (Type. Print)

Jay Bonakdar permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau
once. 20c. Location - City or Town, State Date 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sharon Memorial Park Nov 21,2010 Charlotte NC 4 Donation 5 Other (Specify) re of Funeral Service Licensee Miller Dippel Funeral Home, 6415 Belair Road, Baltimore, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List of CANCER Immediate Cause (Final COMPHINTED HEAD AND NEUK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any second product cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and a for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? page 2 should be detached for Pregnant at time of death 5 Other (specify) 2 □ No Division of Vital Records, P.O. 9 Unknown β 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Tes မ 28c. Injury at Work? 28d. Describe how injury occurred the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 1X Natural Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined filled in by 4 Homicide 24 hours a Funeral I Hospital 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. MIS KES-000 NOVEMBER 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMITHA GANJI, MD 600 North Wolfe St. Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month.

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ NOVEMBER Pg. 2010 4:04 AM HAROLD BOND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 6009 MARLUTH AVE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 CEODOT 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** MARCH, Day, Yea Days 1 X M 2 🗆 F Months Hours **GEORGIA** 219-28-8281 76 **Director** 1934 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a State Director 1 XYes 2 No N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? Funeral 21206 USA 6009 MARLUTH AVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Ves 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALESMAN KELLOGG Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY DUPREE MELFORD BOND 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 FAIR OAKS AVE BALTIMORE, MD 21214 KAREN WALIZER-DAUGHTER Department of Health Important: If item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) GLEN BURNIE, MD ATLANTIC CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1 Enter the dische, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Physician/ Chronic obstructive disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ hed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ★ Residence 6 Other (Specify) 4 Nursing Home 28c. Injury at 27 Manner of Death 28a. Date of injury (Month) Day, 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7602

LICMAN MI)

Bultimore

29d. Date signed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ CONART nce Novemb 11:57A 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** N/A Himore Muco.tml If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min. 1 🛛 M 2 🗆 F 11/05/1930 Maryland 215 28 4169 80 **Director** Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗌 Yes 2 💆 No Glen Burnie Anne Arundel Maryland 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 301 Rain Water Way Unit 102 21060 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married ş If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Chief Financial Officer Schmidt Baking Co. years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Victor Bunce Margaret Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
301 Rain Water Way Unit 102 Glen Burnie, MD. 21060 Malinda Bunce / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 11/16/2010 4 Donation 5 Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatu a of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway ramerous complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease, shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Ph sician/ カケタストッナトル mored of CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MIDCHASIA FARC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Te ALC Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury CORONARI that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗀 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death e detached g Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed' RENA FAILURE 1 Yes 2 No 1 Yes 2 No LIRON: C 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director, Be B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျ 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 - Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) BUKON mD completed cause of death (Item 23a) (Type, Print)

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State Registrar th Honover

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decement's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month eaune Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 210 - 6th Avenue N.E. Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. 220 24 9694 80 Yrs 06/12/1930 Maryland Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Baltimore Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4915 Ballman Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me any injury or other traumatic event, the Me Once. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary U.S. Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marshal Taylor Maude Kump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Morgan / Daughter 4915 Ballman Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 11/17/2010 Baltimore, Maryland 21. Signature of Fulleral Service Lic 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ea Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy performed? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? SON'S House ြုင 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred s after dea... al Director; After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours Funeral Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m n completed cause of death (Item 23a) (Type, Print)

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State Registrar

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To the most and the death, within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	building, etc. (Specify) 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)									cause(s) and manne stated.	er state	
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Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Dis 1 Durial 2	X Cremation	3 Removal from	n State		matory or other p		1 1 / 1	Date 16	20c.	Location - C				
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	Nith with Common		29b. Signature and	title of certifie	Senga	~			ise number 5533	37			ate signed (A		Day, Year)		
			30. Name and addr	ess of person	who completed cau	se of death	(item 23a) (Type, F		203	Ba	Homon	2,1	1dz	wi	4		
	State		31. Date filed (Mont	th, Day, Year)	8 2010 32.F	Registrar's S	ignature 6	barker									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8618 Per FH G909 11/18/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:20 PM Conwas Dule 13 November 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hopkins Bayview Medical Center Johns If Under 1 Year | If Under 24 Hrs. 8. Date opporth
(Month Say, Year) 5 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. 1**X** M 2□ F MD 216-54-2620 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health, and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar invest be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Dundalk 1 Yes 2 □ No Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7964 Kavanaugh Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive 12 Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Conway Joseph Hoos ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7964 Kavanaugh Rd., Dundalk, MD 21222 Joseph Conway - Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-19-10 Middle River, MD Holly Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 24 hours **Physician** Gastro intestinal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ears disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) g physician and stransit the burial-transit law requires that the death certificate be executed *Itopatitis* resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. ed by the a a | I Inknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 928 The page performe certificate 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 13, 2010 MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DVC Baltimore 21224 Monti Eastern MD 32. Registrar's Sig 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5:00 A. M Theresa Juanita Combs Physician/ 2010 November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Hammonds Lane Baltimore Genesis Eldercare If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral (Month Day Year) 38 1 □ M 2 🏻 F Maryland 72 219 26 1028 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 21225 3405 - 4th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Manufacturer Umbrella Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Bertha Ferger ပ္ Steven Lowry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Patricia Lathe / Daughter 3405 - 4th Street 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or page lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SOMONIE disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ed by the at detached for 9 Unknow P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Division of Vital Records, Arthritis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has b lirector, page 2 sl performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certificate: To this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of De within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ひころんりろ 1 ddress of person who completed cause of death (Item 23a) (Type, Print) Glen Bornie MD 21061 Afwood 32. Registrar's Sig State Registrar

DHMH 17 Rev 7/2009

lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 36173

10-08616	Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. [] []	00
Eric Warren Dozier, Jr.	State of Maryland / Department of Health and Mental Hygiene	

		1- For State Registrar		C	ertifica	ate of De	ath			Re	eg. No.		
Physicia	∄n/	Decedent's Name (First, Midd	lle,Last)							Date of Deal	Day	Year	3. Time of Death
Medical Exami	ner		Eri		rren		ier,			lovembe	10, 201	0	0040 hrs
		4a. Facility Name (if not institution Johns Hopkins Hospi		mber)			y, Town, or L Itimore	Location of	Death		4c. Co	ounty of De	eath
F		Social Security Number		7. Age (In yrs	s last birth		Inder 1 Year	If Under	24Hrs F	B Date of Bir	th (MM/DD	yyyyl 9.	Birthplace (State or Foreign
Funeral Director		212-35-7814	1 XM 2 F		5		nths Days		Min.	4-16		1	Country) MD
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any		10a. State 10b. County		10c. Ci	ity, Town o	or Location							10d. Inside City Limits
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Maryland 28a-f show d at once.	Director	10e. Street and Number			-	10f.	Zip Code			1	0g. Citizen	of What C	country?
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	ä	4034 Hillen	Road				2121	L8			US	A	
with	Funeral	11. Marital Status	12. Was Dece		U.S.	13. Was Dec	edent of Hisp ecify Cuban,				- 14.	Race - An White, etc	nerican Indian, Black,
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after	à		orced If Yes, Give Year or Dates:	_			2 X X No					ecify:	Black
hours		15. Decedent's Education (Spe				Decedent's Use luring most of							ss/Industry
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21215-0036 uld be filed within 7 Mental Hygienc. marked other than c event, the Medica	ē	12th grade 17. Father's Name (First, Middle	Last)			асошов.				rst, Middle, M			·VC
a Hy	BeC	Eric Dozie	r. Sr					Shar	ond	a Ran	d = 1 1		
212 buld b Meni marlic eve	2	19a. Informant's Name/Relations			19b	. Mailing Addr	ess (Street	and Numb	er or Rura	Route Num	ber, City o	r Town, St	tate, Zip Code)
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imore, Mi Pages I and 2: nent of Health a ant: If item 27 or other traum	- 1	4 Donation 5 Other S		m State		lawn	Cem				Bal		ID
Baltimore, permit. Pages 1 ar Department of Hee Important: If iter injury or other tr	ı	21. Signature of Funeral Service				22. Name a	nd Address	of Facility	Mar	ch Ea	st F	/H	D 01000
™ 88 ™		13n C/2											ID 21202
Physician		23a. Part I. Enter the disease, or failure. List only one cause		used the dea	th. Do not	enter the mod	de of dying, s	such as car	diac or re	spiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wounds (2) of Head and Torso											
		or condition resulting in death)	Due to (or as a	consequence	of):								
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Box 68 e death certifithe attending ed for use as	Sici		4 Pregna	int at time of	death 5	Other (S	pecify)						
the de	Physician	Part II. Other significant condit	9Unknow		t resulting	in the underly	ing cause giv	ven in Part	1	23e. Did to	bacco use	contribute	to the cause of death?
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SOFC law re has be	힐								_	autop: perfor	med?	prior t death	to completion of cause of ?
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Hospi 24 hou Funer tely fil	OF	29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowle	edge, deat	h occurred at	the time, date	e and place	e, and due	to the cause	e(s) and m	anner as s	tated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Directory completely filled in by the	ledical	one) 2 Medical Exa	miner: On the basis of and manner sta	f examination ated.	and/or in	vestigation, in	my opinion, o	death occu	irred at the	e time, date a	and place,	and due to	the cause(s)
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	ŀ	30. Name and address of person											
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Sta Regist		31. Date filed (Month, Day, Year)	32. Reg	gistr e r's Signa	ature	1 ho	Rad						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 10: 22 AM NEVEMBER 201 Medical Facility. Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death en Medical Lar syaw It Wel hiva UVULP Social Security Number If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1 □ M 2X□ 90 **Director** 220-05-3002 06/18/1920 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Linthicum 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 515 Forest View Road 21090 U.S.A. items? within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc 9 ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Catalog Department 12 Sears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ pe James Τ. Cox Sadie Ε. Wilkerson t. Page 1 and 2 should be treent of Health and Merctant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3401 Silver Maple Drive permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Mr. Robert W. Drury / Monrovia, MD 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 11/19/2010 Glen Burnie, MD Sonature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r. spiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ NOVO disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dusito (or as a consequence of) that the death certificate be executed and as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Se 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? detached for Month Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> page 2 should be or Attending Physician: The law requires Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has To the Hospital to to the within 24 hours after death.

To the Funeral Director, After this certificate has remoleted filled in by the funeral director, page? autopsy performe death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 2 No 1 🗌 Inpatient 2 🗗 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36175 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010 Öctober 1:45 Рм Theresa Foy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 1000 Franklin Avenue #218 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔽 F Maryland 79 Feb 14, 1931 Director 213-28-3326 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantual must be notified at once. MD 1 ☐ Yes 2 ▼ No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue #218 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ∐Yes 2 💢 No Specify: white þ Specify: 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Waldych Anna Szajner ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore City Police Department 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signatura of Funeral Servi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician provery /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any caching to important cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
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the death certificate be executed P.O. Box 68760, The law requires that Division of Vital Records, Attending Physician:

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the within 2

> State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who con

20Hingham, 2. Registrar's Sign

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 Suicide

29a. Certifier

Medical

4 Homicide

6 □ Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Peter F. Gips 6:45 November 2010 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 650 Western Shores Blvd Port Republic Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 81 Director Jan 24, 1929 060-24-1761 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD r than "natural", or items 23a or 28a-f sh Calvert Director Port Republic 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 650 Western Shores Blvd 20676 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 【 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 marketing specialist Dept of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental P Important: If Item 27 Is marked ot any Injury or other traumatic ever Floris A. Gips ပ Dingeza X. Staat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Gips/spouse 650 Western Shores Blvd Port Republic, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on ear line. Immediate bruse (Final disease or condition resulting in death) Approximate interval Between Onset and Death **Physician** AE YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W. Bennetting. 25156 nonles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trueman Rd. W. Bennett M.D 32. Registrar's Signal State Registrar

P.O. Box 68760.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician/ Month Day 10:17 PM **GEHER** CLARA 2010 Joven Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Hospital O¢. Cit If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 □ M 2 🖵 F 0975071923 NY Director 087-12-2971 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 Tr No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 11110 HIDDEN TRAIL DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: 3 ▼ Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARRY BABROW ANNA SELTZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIETT G. BAVERMAN/DAUGHTER 11110 HIDDEN TRAIL DRIVE, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State ANSHE EMUNAH AITZ CHAIM 11/17/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acrts Stenes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 1 No Yes 2 No 1 Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

31. Date filed (Month, Day, Year) NOV 1 8 Registrar

only one)

29b. Signature and title of certifie

A. Jefferson, M.D.

32. Registrar's Signature

cf

M.D

Sinoi Hespital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reltime

188191579

29d. Date signed (Month, Day, Year)

Journbe

14,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month INYARD 2018 ICHELLE YNN il 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL LENTER BALTIMORE 7. Age (In yrs. last birthday) 53 Yrs. **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 217-70-1816 Months Min. (Month, Day, Year) 2/16/1954 Davs Hours Country) Director MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits MD Washington Hagerstown 28a-f 1 Yes 2X No 10e, Street and Number 10g. Citizen of What Country? 23a or 10f. Zip Code 21740 943 Main Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence Elizabeth Louis B. Anthony Carter 19a. Informant's Name/Relationship (Type, Print) Andrea A. Ginyard/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 6078 Wild Ginger Ct., Columbia, MD 21044 Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 11/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD 21. Signature of Funeral Service Licenser Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413. Baltimore, MD Mai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END 5 TAG LIVER disease or condition EARS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Pregnant at time of death 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY Division of Vital Records, FAILURE 1 Tes 2 No 3 Probably 4X Unknown FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL autopsy 2 N 1 Yes 2 No 1 🗌 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 5666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Scurh (Thein SF

ERIC D, MARTIN MD) UNIVERSITY OF

Registrar M DHMH 17 Rev 7/2009

State

32. Registrat's Signature

MARYLAND

MEDILAL

CENTER BALTIMURE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eau 8:14 AM VID am NOV. 2010 Medical 4a. Facility Name (if not institution, give stre 4b. City, Town, or Location of Death et and number 4c. County of Death Examiner timore edica IMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 🔀 M 2 🗆 F Months 224-34-6804 81 Yrs. Director 27/1929 Usual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Medical Examiner must be notified at Director Baltimore MD 1 XYes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1401 Decker Ave items 23a 21213 US 12. Was Decedent Ever in U.S.

Armed Forces?

1 Ses 2 No 1953

If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. à "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "no any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sparrows Pointt Elementary/Seconday (0-12) College (1-4 or 5+) Ship Yard Bethlehem Steel 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Gilliam Sallie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 1401 Decker Ave Baltimore, MD 21213 Gladys Gilliam 20b. Place of Disposition (Name of cemetery, crematory or other place Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State 11/23/201 Burial 2 Cremation 3 Removal from State Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip . Signature of Funeral Service Weatherford imore, MD 212₁₃ Baltimore, 2431 E. Oliver st. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death enysician/ disease or condition Medical resulting in death) Examiner Z weeks Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine lue to or as a consuluence of the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? after death.

Director: After this certificate I 2 No 1 🗌 Yes Yes 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🗹 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27, Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) veene ona 31. Date filed (Month, Dav. Yea State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	ate of Maryland / Dep: <i>Ce</i>	artment of He ertificate of D		ntal Hygier Reg. I	2010	35180	
			Decedent's Name (First, Middle, Last)		2.	Date of Death		3. Time of Death		
	Physicia /Medic		Audrey Hanna Goldsb		N		5 2010	3:30 A M		
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death				4c. County of Death			
. "			14508 Homecrest Roa	Silver Spring			Montgomery			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last birthday 2 Trs. 88 Yrs.	Months Days	Hours Min. Ma	Date of Birth (Month, Day, Yea ar 2, 19	9. Birth 22	place (State or Foreign ntry) unk	
1212 00	/land	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			1	10d. Inside City Limits	
	a-fst		MD Montgomery	Silve	er Spring				1 □Yes 2√√ No	
	or 28)ire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?	
	23a	ra	14508 Homecrest Roa			0906		USA		
	J within 72 hours after death with the Maryland glene. If than "natural", or items 23a or 28a-f show the President Examination in citing a	by Funeral Director	1 Never Married 2 Married	Vas Decedent Ever in U.S. \text{\text{lamed Forces?}} \text{\text{\text{L}} No} \text{\text{\text{loss}} Yes, Give} \text{\text{\text{loss}} ver Dates:}	. Was Decedent of His If Yes, specify Cuban 1 □Yes 2∑ No	spanic Origin? (Specif , Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.	
	n 72 hor	Completed	15. Decedent's Educatio (Specify only highest grade cor	mpleted) (Giv	a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)			16b. Kind of Business/Industry		
	filed within Hygiene. Ather than "	шо	Elementary/Secondary (0-12) College (1-4or 5+) retail				Hutzler's Dept Store			
	othe vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (F				
	2 should be and Mental is marked aumatic ev	5 E	Leroy Goldsborough			Isabel1	Goldsboı	cough		
	alth and I		19a. Informant's Name/Relationship (Type. F Barton Clemens/nep	· ·	ling Address <i>(Street al</i> 0 Glen Oak	nd Number or Rural F s Drive Sa	Route Number, Ci Inta Barl	ty or Town, State, Zipoara, CA	93108	
	permit. Pages 1 and 2 should be Departiment of Health and Menta Important: If Item 27 is marked any injury or other traumatic enone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposer cemetery, critical state	position (Name of ematory or other place) Date	e 20c	Location - City or To	own, State	
Bait	permit. Departr Importa any inju		21. Signatus Functi Servic Licensee Rom S Was	Re, Director S	22. Name and Address tate Anato altimore,		555 W. B	altimore S	Street	
ecords, P.O. Box 68/60,	Physician /Medical Examiner	Physician/Medical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, scheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	leath certificate be executed attending physician and for use as the burial-transit		d	If yes, outcome of pregnancy				23d. Date of deliv	very	
	0 0 0		in the past 12 months?	action pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)				Month Day Year		
	law requires that the de as been signed by the 2 should be detached	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒No 3 ☐ Probably 4 ☐ Unknown		
	ician: The law req certificate has beer rector, page 2 shou	Completed	Hyper ligidem	a		24a. Was an autopsy performed	prior to completion of cause of death?			
<u>a</u>	lan: Triffica ttor, p	a)	25. Was case referred to medical 26. Place of Death (Check only one)						2 🗆 110	
	di is	O B	examiner? 1 ☐ Yes 2 ☑ No Hosp	ital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Othe	r: 4 ☐ Nursing Home	5 A Residenc	e 6 □Other (Spec	cify)	
5	To the hospital or Attending Physician: initin 24 hours after death. To the Funeral Lirector: After this certific completely filled n by the funeral director,	tion: 1	27. Manner of Death 12. Natural 5 Pending 2 Accident investigation		year) 28b. Time of					
		Certification:	a Could not be	Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					ral Route Number,	
		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the within To the Comp	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/11/10							
			30. Name and address of person who completed cause of "leath (Item 23a) (Type, Print), (SO) Bulief Mill Not, N. Botomac, MD20778							
ŀ	Sta Registr		31. Date filed (Month, Day, Year) NOV 18 2010	32. Registrar's Signature	KN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month mber Day q Physician/ Jerome Gaber Year 2010 9:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4730 Atrium Court Baltimore Owings Mills Social Security Number If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Date of Bill. (Month, Day, une 25 Hours Director 88 New York 217-18-1401 June Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 ☐ Yes 2 ☐ No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 Atrium Court 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced 42-46 Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) medical doctor healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sarah Sher Jacob Gaber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State Zic Code) 618 St. Dunstans Road Baltimore, MD 21212 Robin Gaber/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Fune | Service Ronal c State Anatomy Board 655 W. Baltimore Street Raltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, scheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End-Stage Dementia Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 24 hours after death. Funeral Director: After this certificate 2 No 2 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Assisted Living facility Other: 4 Nursing Home 5 Residence 6 Other (Specific 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 \square Pending injury Accident 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MSKijapalne M. D DOUS7465 11/10/10

Registrar

State

5-203, Baltimore, MD. 21209

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)
N-5. Raja payse, M·D - 2835 5 m i m Av -

32 Registrar's Signatu

N-5. Rajaparse, M.D

31. Date filed (Month,

NOV 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	e of Maryland		irtment of H tificate of D			giene Reg. No.	10 3	6182
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		Time of Death
	Physicia Medic		HELEN L	HOROWIT	Z			Novemb	er 15	Year 2010 C	14:48 AM
	Examin	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Baltimore N/A									
	Funeral		5 Social Security Number 6 Sox	7 Ago (In um los		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		(State or Foreign
	Director		089-12-1886	x 87	Yrs.	Months Days	Hours Min.	037167	1923	Country)	NY
	nd now	_	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	ation				10d. I	nside City Limits
	larylar la-f sl	ectc	MD BALTIMORE	,	LTIMO						1 ☐ Yes 2 ▼ No
	the N	Ξ	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	h with	Funeral Director	8911 REISTERSTOWN RO	AD, #221		21208			USA		
_	r deat		Arme	Decedent Ever in U.S. ed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		e - American In ck, White, etc.	ndian,
200	safte ral", c Exam	ed by	If Yes	Yes 2 XNo s, Give or Dates.	1	☐ Yes 2 XNo	Specify:		Specify	WHIT	E
215-0036	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade compl	eted)		ent's Usual Occupa	ation uring most of worki	na	16b. Kind of B	usiness Industr	у
2	ithin 7 ene. • than he Me	Completed	Elementary/Seconday (0-12) Colle	ge (1-4 or 5+)	Ìife. DO	NOT use retired) KKEEPER	J		1115	GOVERNM	ENT
ק ק	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show dother, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			KREELER	18. Mother's Name	(First, Middle,			
Maryland	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25e or 28a-f sho is aumatic event, the Medical Examiner must be notified at	2	BERNARD	LANDA	U		BELLA			UNKNOW	N
Mar			19a. Informant's Name/Relationship (Type, Print)		l .	•	and Number or Rura)
	1 and 2 should be file of Health and Mental B fitem 27 is marked o r other traumatic eve		IRA HOROWITZ/SON 20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	P LANE,	Date		21044 - City or Town, :	State
Ē	Page 1		1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	metery, crem	natory or other place WOLINER T SOCIETY	e) 11/1	7/2010		IMORE,	
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce.	J	21. Signature of Funeral Service Licensee	1 1		. Name and Addres	s of Facility S	OL LEVI	NSON &	BROS.,	INC.
	σ□ = α ο		23a. Part 1. Enter the disease, or complications	that acrossed the death	Do not onto		STERSTOW				
			shock, or heart failure. List only one cause	on each line.			g, such as cardiac c	i respiratory an	1651,	Inte	proximate erval Between set and Death
	Priysician/ Medical		disease or condition resulting in death) a. PC	Ilmonary (Forema					-1	acy
Examiner Congestive teart											y ears
	ed sit	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	e to (or se a conseque	anes of;:						
	xecute n and al-tran	Еха	that initiated events C. ———	ue to (or as a conseque	ence of):						
00	icate be executed physician and s the burial-transit	edical	d								
	ertificat ling ph e as th	/Me	IF FEMALE:	s, outcome of pregnan	2014		<u>.</u>				
Box	attenc for us	cian	in the past 12 morates?	Live Birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day	/ Year
. B	the de by the ached	Physician/M	9 Unknown 9	Unknown							
, P.O.	s that igned be det	þ	Part II. Other significant conditions contributing	g to death but not resu	ilting in the u	nderlying cause giv	ren in Part I.		obacco use conf		
rds	equire	eted					.*				y 4 Unknown
Division of Vital Records,	ician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Completed						24a. Was auto perfo	psy ormed2	prior to comple death?	etion of cause of
E E	an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Check	1 🗌 Yes	2 No	1 ☐ Yes 2 ☑	1 No
Ž	hysici nis cer I direc	To E	examiner? 1 Yes 2 No Hospital:	1. Inpatient 2 .	R/Outpatier	ot 3 DOA Othe	er: 4 Nursing Ho	me 5 🗆 Resi	dence 6 🗆 Oth	er (Specify)	_
n of	ding P. h. After ti funera	ate:	1 Natural 5 □ Pending	Date of injury (Month, Day, Year)	28b. Time of injury	work	/ at ? Yes 2 □ No	28d. Describe l	now injury occur	ed ·	
Siol	Attend r death ctor;	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At hor	ne, farm, stre		Yes 2 LINO	28f. Location (Street and Numb	er or Rural Rou	ute Number,
	tal or, rs afte al Dire		4 - Hornicide determined	building, etc. (Specify)				City or Tov	vn, State)		i i
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the control of the contr	ne basis of examination	and/or invest	tigation, in my opinio	on, death occurred at	the time, date a	and place, and du	ue to the cause(s	
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practic	PILET: 10 The best of my	кпоwledge, с	29c. License		e, and due to th	ne cause(s) and m 29d. Date signe		
			Korrina Abadille	a, M.D		RES	- 000		Novemb	er 15,	2016
			30. Name and address of person who completed				0 0-	1 m 1 10			
	Sta		Katring Abadilla, 31. Date filed (Month, Day, Year)	32. Registrar's Signatu		Hospital	of Bai	timore			
	Registr		NOV 18 2010	J. S. C.	• , .						

Helen

Known as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dorothy Virginia Hansen November 16, 2010 10:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Stella Maris Hospice Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/29/1925 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months 0ays Hours 84 **Director** 220-12-5189 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Mediral Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Harford MID Abingdon MX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Box Hill South Pkwy, #121 21009 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Yes, Give 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James B. Leffers Stewart Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1759 Balsam Ave., Kissimmee, FL 34758 Karen L. Helmcamp / Daughter Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crem. 11/19/2010 20c. Location - City or Town, State ō 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD21203 U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MELANOMA Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Dire to fur as a consectionne or cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation hours after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Manth, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, 2300 DULANEY VALLEY RD.

DHMH 17 Rev 7/2009

State Registrar

NOVEMBER

32. Regist it Sign ture

TIMONIUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08787 State of Maryland / Department of Health and Mental Hygiene Dorothy Jane Jackson 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Month Day November 15, 2010 2205 hrs DOVOTIN Jane 1ical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Pikesville **Baltimore County** 813 Painted Post Court If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Baltimore Pikesville MD Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21208 Painted Past Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 2 Married 1 Never Married 2 No 1 Yes Black 4 Divorced 1 Yes 2 No specify: If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed of College (1-4 or 5+) Elementary/Secondary (0-12) Social Worker In grade Tars 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Janie Litaker Melron Ingram 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27713 19a. Informant's Name/Relationship (Type, Print 600 Courtney Creek Boulevard, Apt. 836 Durham, NC lames N. Jackson 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Mt. Gilead, NC Cemetery MOSIC Hill Donation 5 Other Specify 22. Name and Address of Faility Vaughy C. Greene Fureval Sorvices Signature of Funeral Service License MD 21133 Road Randallstown Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or respiratory arrest, shock, or heart Physician een Onset and /Medical Death a. Intracerebral Hemorrhage Immediate Cause (Final disease Éxaminer or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED tending physician a AMENDED 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 V No 9 Unknown 9 signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 Unknown þ HTN, arthritis Completed Records, 24b. Were autopsy findings available autopsy prior to completion of cause of death? icate has l page 2 sh performed? ✓ Yes 2 No 1 🗸 Yes this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes မ After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ō 27. Manner of Death 1 V Natural 1 Yes 2 No 5 Pending I Director: 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined filled (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar NW LO

Laron Locke MD

31. Date filed (Month, Day, Year)

29b.

State

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 16, 2010

and manner stated

32. Registrar's Signature

ascert.

ddress of person who completed cause of death (Item 23a) cke MD. Assistant Medical Examiner 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month // Physician/ dward Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 121 Windsor bardent Baltimore more 8. Date of Birth Month, Day Social Security Numbe If Under 24 Hrs. 9. Birthplace Country) Funeral Age (In vrs. last birthday) 1 **X** M 2 □ F 3 Months Hours Min 225-26-3850 Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Completed 3 Widowed 4 Divorced 1945 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) onday (0-12) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Mai ပ္ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 2121 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 11-30-2010 Wings 21. Signature of Funeral Service Ligensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 85 R inset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown ed by the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 Yes 2 No Yes å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 잍 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) the Funeral Director: After the pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Lillian

31. Date filed (Month,

Minic

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-08666 Robin Jacobs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

obin Jacobs		State of Maryland / Department of Health and Mer 1- For State Certificate of Death	ntal Hy		201 ag. No.	0 36186
Physicia Medical Examir	ın/	Registrar 1. Decedent's Name (First, Middle,Last) ROBIN F JACOBS		Date of Deat Month November	h Day Year	3. Time of Death 1905 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location Baltimore			4c. County of D	eath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If		1		Birthplace (State or Foreign Country) MD
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			7 = 3 3	10d. Inside City Limits
th the Maryland 23a or 28a-f show	Director	MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code		10	0g. Citizen of What	1 X Yes 2 No
death with the or items 23a or must be notifie	uneral Di	7111 PARK HEIGHTS AVENUE, #207 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Status III Never Married III			USA 14. Race - A White, e	merican Indian, Black, tc.
rs after dea ural", or it	by F	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No No specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	fy:		Specify:	WHITE
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT			SOCIAL	SECURITY STRATION
21215-0036 Muld be filed within 7 Montal Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) EDWARD SMOLARZ JAN	NICE	•	laiden Surname)	MORSTEIN
C 25 E 24	T ₀	19a. Informant's Name/Relationship (Type, Print) MARK SMOLARZ/BROTHER 20a. Method of Disposition 19b. Mailing Address (Street and Num 9213 HARVEST RUS 20b. Place of Disposition (Name of cemetery,	SH ROA			, MD 21117
Fa Pa Pa or o		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: BETH TFILOH CONG.	Pa	14/2010	BALTIM	IORE, MD
Balt Bernit Depart Import injury		21. Six atu of Funeral Service Lieensee 22. Name and Address of Facilit 8900 REISTERS 23a. Part 1 Fater the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line. Complications During Surgery	SUL STOWN	ROAD.	SON & BRC PIKESVILI est, shock, or heart	
/Medical Examiner		failure. List only one cause on each line. Complications During Surgery Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	7 For	Kemova	Of An	Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ecuted and - transit	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
), be ex sician	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
Box 68760 e death certificate be attending physic for use as the by	Physician/Me	past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	oic pregnand	cy	Month	Day Year
rds, P.O. E requires that the of been signed by the	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.			e to the cause of death? Probably 4 Unknown
S w lass	ompleted			24a. Was a autop: perfor	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 No
Vital Rechysician: The this certificate	o Be C	25. Was case referred to medical examiner? 1 Yes 2 No Other, Document 1	=			Other:
sion of \alpha ttending Phydeath. ctor: After tly the funeral	cation: T	27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending Investigation 11-4-10 unknown 28b. Time of Injury 28c. Injury at Word 1 Yes 2 X	No S	subject pre-op	now injury occurred arrested	
	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, e (Specify) hospita1				r Rural Route Number City rsity Of Md.B Greene St
Div To the Hospital or within 24 hours at To the Funeral Dit completely filled in	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated. 29b_Signature and title of certifier 29c. License number	occurred at t			to the cause(s)
		O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)			November 12	11
St	ate	Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 2	1201		
Regist						1

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 00 11:04 AM 2010 alem Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** mor yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 **X** M 2 □ F Months -162 Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director mo 1 Xes 2 No 10e. Street and Number 10g. Citizen of What Country? by Funeral K_{0} 2 and Mental Hygiene. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ¥ Yes 2 □ No 1 Never Married 2 Married Yes. Give Baltimore, Maryland 21215-0036 19 1 Yes 2 No Specify. 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 216 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ma permit. Page 1 and 2 should t Department of Health and Me Important; If item 27 is mark 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ko Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State mD-4 Downtion 5 Other (Specify) re of Funeral Service Licenses 21229 23a. Part Enter to disease, or complications that caused shock, or head failure. List only one cause on each line. Immediate Cause Final disease or condition disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner attending physiclan and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Tes 2 🗌 No Completed peen . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ၉ 1 🗌 Yes 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after death Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Fractioner: To the local of my knowledge of all occurs of the time. I also and due to the cause (s) and manner as stated. (Check within 2. 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name af

Day, Year)

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person who completed cause of death (Item 23a) (Type, Print)

A Gall 2300 W. Ba

🧖. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month / 3. Time of Death Physician/ :3 OAM 0 Medical Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace **Funeral** 1 🗆 M 2 🕽 Country) Director ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits **Funeral Director** umbia 1 X Yes 2 No 01 ON 10f. Zip Code 10g. Citizen of What Country? 21044 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Blac 1 ☐ Yes 2 🔀 No Specify 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) 2th Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre Town, State, Zio Codel Saunders 21217 Grenda (20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran and that initiated event Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown P.O. cate has been signed by ; page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 ☐ Unknown 2 🗀 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending injury work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner (Check 3 Certifying Nurs actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Letha Wentz Leszak 2:20 P. M November 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dulaney Valley Assisted Living Baltimore Baldwin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 M 2 X F Months Davs Hours Min. 017257193 Director 299 26 6044 79 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director Baltimore Perry Hall Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must he Funeral 9220 Snyder Lane 21128 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates Completed 3 🔀 Widowed 4 🗆 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William A. Clark Ethel E. Stoffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Wentz / Daughter 9220 Snyder Lane Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 11/17/2010 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, 4001 Ritchie Highway Baltimore, Maryland 21225 namerous 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ ☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death Day Month Year 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe safter death.

Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to ___ cal funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) 2 No 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 1 ☐ Yes 2 ☐ No Investigation Could not be Accident filled in by the Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

NEWEMBER 16 29b, Signature and title of certifier

State Registrar 30. Name and address of per

31. Date filed (Month, Day,

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DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day Year Month even 50 A M Jovenbe 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Grenessi Baltinole Baltimore eming 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number Months Hours Davs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry /Secondary (0-12) College (1-4or 5+) abover 17. Father's Name (First, Middle, Last) Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number Town, State, Zip Code) Mother Md. ZIZIZ 20c. Location 20a. Method of Disposition 1 ☐ Burial 2 3 Removal from State Cremation 5 LJOther (Specify) 21. Signature of Funeral Service Lig 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Meningri disease or condition resulting in death) Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the buria o cate has been signed by the page 2 should be detached Records, certificate Vital funeral director, o this After t Division

Physician

/Medical

Examiner

Funeral Director

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Be Completed

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Funeral

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than many Injury or other transmittee event, Ira fluctical Examinat must be notified at

Physician

/Medical

Physician/Medical Be Completed by Medical Certification: To

Examiner

5 Pending investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 2010

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year, 182010 NOV

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

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Registrar

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 400 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 L Yrs. 220-30-7135 78 MAY 21,1932 WASHINGTON, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∏ Yes 2 ☐ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1641 N. AISQUITH ST. 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 MEDICAL TECHNICIAN MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN BRASKER WARREN FANNIE ESTELLE TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 3817 MAYBERRY AVE BALTIMORE, MD 21206 GERRI D. MILLER-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/18/10 GLEN BURNIE, MD ATLANTIC CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Enter the disease, er con or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) :/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 has 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မှ this 28a. Date of Injury (Month, Day Y 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural within 24 hours after death.

To the Funeral Director: After completely filled in by the full 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

State

31. Date filed (Month, Day, Year) NGV 18 2010

Barbara

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

He

32. Aegistrar's Signature

DHMH 17 Rev 1/2001

RES-000

November 13, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryla State Registrar		tificate of Dea		,	Reg. No:-	010	36193
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Charles Trigg Moore				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc		Nov.	4c. C	2010 County of Death		
1	F. mayel		124 Dutrow Road 5. Social Security Number 6. Sex 7. Age (In yrs.)	. last birthday)	Westmin	nster Under 24 Hrs.	8. Date of Birt	h	Carr	place (State or Foreign
Н	Funeral Director	1	215-78-4199 ^{1 □XM 2 □ F} 51	Yrs.		lours Min.	(Month, Da	v. Year)	VA.	ntry)
	land show dat	tor		City, Town or Loc						10d. Inside City Limits
	ie Mary ir 28a-1 notifie	Director	WV Berkeley 10e. Street and Number	неад	esville			10a Citiz	en of What Cou	1 🗆 Yes 2 🔀 No
	n with the	Funeral	8791 Hedgesville Road		25427				SA	
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hispar f Yes, specify Cuban, M ☐ Yes 2 ☑ No Sp		sify Yes or No- lican, etc.)		1. Race - Amer Black, White pecify:	
12-CI	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupation	n ng most of workin	g	16b. Kind	d of Business I	ndustry
717	within giene. er thar t, the M	S	Elementary/Seconday (0-12) College (1-4 or 5+)	1 .	o NOT use retired) andyman			self	empl	oyed
yland	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Charles Moore, Sr.			. Mother's Name Viola			ırname)	
Mary	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and I					
e,	1 and 2 s of Health item 27 other tra		Donna Boggs, companion 20a. Method of Disposition 20b	Place of Dispo	sition (Name of		d., He		ation - City or	, WV 25427 Town, State
baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ★ Other (Specify) in state		natory or other place)					
Bail	permit Depart Impor any in once.		21. Sign to the Luneral S. rvo Licensee Wixecta	r 22	Name and Address of State Anato Baltimore.	omy Boar	cd 655	W. Ba	altimor	e Street
	nysician/ Medical Examiner		23a. Par 1. Enter the disease, or complications that caused the de shoot of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	CAN		uch as cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
	cate be executed physician and the burial-transit	Medical Examiner	if any, leading to immediate Cause (Disease or liminry that initiated events resulting in death) Last Due to (or as a consection of the c							
ROX	death certific he attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)			20	3d. Date of deli Month	very Day Year
ds, P.O.	law requires that the nas been signed by t e 2 should be detach	ρ	Part II. Other significant conditions contributing to death but not r	esulting in the u	nderlying cause given i	in Part I.				the cause of death?
Ž	The law ate has page 2	Completed					24a. Was auto perfo 1 \(\sum \) Yes		prior to death?	opsy findings available ompletion of cause of 2
Vita	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	☐ EB/Outpatier		of Death (Check		dence 6	Other (Speci	EMOS HOME
on of	anding Ph ath. rr: After th	Certificate: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. Time of injury	work?	2 No	8d. Describe h	now injury	occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVISI	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec		eet, factory, office	2	28f. Location (\$ City or Tov		Number or Run	al Route Number,
	ne Hospil n 24 hou ne Funera pleted fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my kno only one) 3 Certifying Nurse Practioner: To the best of	ion and/or invest	tigation, in my opinion, d	death occurred at	the time, date a	and place, a	and due to the c	ause(s) and manner stated.
	To the virth com		29b. Signature and title of certifier		29c. License nur			29d. Date	signed (Month	
			30 Name and address of person who completed cause of death (It	em 23a) (Type, F			CF M	D 21	/	
Ü	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sign		e. d	- 7000	,	У .	f are a	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 21225VI RESSIE 12 45 PM NOVERIBER 142016 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Baltimore andalistown If Under 1 Year | If Under 24 Hrs. | 8. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 M 2 F 93 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Expression rough by northed at andallstown Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3944 Harkate 21133 U. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: Black ģ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Morker 8th arade NIA If Item 27 is marked other or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental anuel ertha 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Pay Harkate andallstann VIVIAN Daughter Way Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. King Klemorial Park 1420 2010 Windsor Mill, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaugh re of Funeral Service Licensee C. Greene Funeral Services Road Randallstown, MD 21133 23a. Part 1. Enter the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus VEinal **Physician** UROSEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami Cause (Disease or ir ju that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending pt I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 🛂 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deatl filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K.S.RAO.TIO. 043462

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year,

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18 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Court JA

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Month VET 3:10 PM ()November Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Medical Cente Glen Bur Anne Arunde Social Security Number 8. Date of Birth (Month, Day, Ye Sept. 19 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Min. Maryland Director 218-36-9817 71 Sept. ,1939 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor 10a State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Co. Glen Burnie 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1008 Dumbarton Road 21060 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) the 8 yrs. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be nent of Health and Ments Robert Thomas Bateman Doris Lorraine Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. Mr. Walter M. Overfelt, Jr./Husband 1008 Dumbarton Rd. Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 11/23/2010 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation _M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NON-ST ELEVATION MYOCARDIAL INFARCTIC disease or condition resulting in death) Medical Examiner oronary Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year signed by the at Id be detached fr g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be preumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed?
☐ Yes 2 💢 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 N Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a 29a. Certifier Example 1 Example 2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one)

10 State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

lanica Novacie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr. Glen Brune

WD

32. Registrar's Signature

based.

29c. License number D 68123

DANICA NOVACIC

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month - 16 - 2010 12:00P M CHAEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Hours 1 → M 2 □ F Month Day Year) 1-18-1944 264-66-1488 66 RT **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 8903 STONE CREEK PLACE #T2 21208 USA filed within 72 hours after death val Hygiene. d other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

11 Yes 2 No

11 No

12 No

13 No

14 No

15 No

16 No

17 No

18 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 XXo Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) PROPRIETOR AUTOMOTIVE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last should be file and Mental F မ PESACOV ROSE SILVERMAN OSCAR permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
PHYLLIS PESACOV / WIFE . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8903 STONE CREEK PL, #T2; BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11-18-2010 RANDALLSTOWN, MD BETH EL MEM. PARK 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign ure Funeral Service Licenses 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician OBSTRUCTI YPAP. HPONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cadse of death? <u>م</u> LIVER CANCER, LOCALLY METASTATIC 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 2 DIABOTES MELLITUS 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 1 Yes 2 No certificate Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Sp. 1 Tes 2 🗔 📈 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

eral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

32. Regis

far's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Stephanie Lynn Piaskowski 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Baltimore-Washington Medical Center Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 214-50-4756 1 □ M 2 🕱 F Months Director 63 Sept 1947 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Glen Burnie MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1730 Saunders Way 21061 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 0. Black White etc. 1 Never Married 2 Married Completed by 1 Yes 2 **X** No 3 Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Office Supervisor State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mirielle Province Eugene Debbs Helmbright should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11318 Bridlewood Dr., Unionville, VA 22567 Robert Maygers / Son Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 11/17/2010 Woodbine, MD injury 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licen 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 2 *Dorota Marshall 1203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ancev Physician/ disease or condition resulting in death) a. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the bunal-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 🗌 Yes 2 🖾 No within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗗 Inpatient 2 🗆 Certificate: To ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 365 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Stephan

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RYLAND 5:30 P M PERRY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE BAYVIEW MEDICAL CENTER HOPKINS If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 💢 M 2 🗆 F Hours (Month, Day, Mary Land 217-70-1207 Director 54 Mar Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Y Yes 2 □ No MD Baltimore 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 243 N. Fulton AVenue 21223 USA items 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces2 1 ☐ Yes 2 ☐ No 0 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 Tes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 XWidowed 4 ☐ Divorced b1ack Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ryland Perry 0 construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ryland Perry Mary Eleanora Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3603 Monterey Road #A Baltimore, MD Gail Kelly/sister 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 👿 Other (Specify) in state Signatur of Fundal Service Licensee ²² Name and Address of Facility Board 655 W. Baltimore Street Director nn <u>Baltimore</u> MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ CARDIAC ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner INTRAVASCULAR DISSEMINATED Securitally list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) INSUFFICIENDER Hospital or Attending Physician: The law requires that the death certificate be executed RENAI attending physician and for use as the burial-tran that initiated events CERTIFICATION Due to (or as a consequence of): resulting in death) Last Physician/Medical SKIN RURN Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No မ 1. Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred subject set sufmire while melting 28b. Time of 28c. Injury at Certificate: 5 Pending work? ☐ Natural 2. □ Accident 3 □ Suicide Detober 31, 2010 7:48 PM Investigation I novietim off of wiring 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 200 block N Fulton Ave determined Rowhame Bultmary MD 21223 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie 2 🗆 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and thie of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar FASTERN NEWYE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32. Registrar's Signature

CORDOVA

037169

BALTMORE

NOVEMBER, 01, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month SHIRLEY 02142AM JACKIE RIVER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL ALTIMOR HARBOR 8. Date of Birth (Month, Day, Ye) Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 69 1 M 2X 3XF Hours 217-58-4495 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Baltimore MD na 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 847 Herndon Court 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Ulidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Housewife 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Corrine Pickens James Howard 1 and 2 should b of Health and Mei item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 847 Herndon Court Balto, MD 21225 19a. Informant's Name/Relationship (Type, Print) Frank Rivers-Husband other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite Page 1 1 Burial 2XXCremation 3 Removal from State injury or Greenmount 11-18-10 Balto, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H any. 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PTICEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PIRATOR WITH LEFT HILAR MASS Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit BILATERAL or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> ECFUSION 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an HYPER TENSION, CORONARY autopsy this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours at the Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) RESIDENT RES NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21225, MD BALTIMORE SOURABH S. HANOVER ST 3001

DHMH 17 Rev 7/2009

State Registrar Day Year) 2010

31. Date filed (Mo

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh G909 11/18/10 TT
State of Maryland / Department of Health and Mental Hygiene
amend #12 Per FH G909 11/18/10 JH
Reg. NO. 0 | 0 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov 12, 2010 Year James George Rutter, Sr. 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard Shangri La Assisted Living 187<u>-05-7270</u> -167-05-7271 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month th, Day, Year) Jun 5, 1916 Director 94 PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director MD Howard Columbia 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7420 Sandalfoot Way 21046 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. ed Force Black, White, etc. Completed by 1 Never Married 2 Married = No 5/19-12 XXYes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates. - Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Research Technician Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Armstrong Rutter Emma Nightingale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Rutter, Jr. Son 7420 Sandalfoot Way Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral bervice Licens Enter the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus on each line Immediate Cause (Final nset and eath Physician, 05m disease or condition resulting in death) Medical ue to (or as a consequence of): Examine quantially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death? 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Sp ASSISTED 2 X No In instruct ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town. State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIES 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 18 2010 Registrar

		1 - State of Maryland / Department of Health and Certificate of Death	i Mentai m	Reg. No.	
Physicia			2. Date of D Month NOV 15,		ear 2:15 P M
/Medic Examin		the contract of the contract o	ath	4c. County of Baltimor	
Funeral Director		5. Social Security Number 218-12-6517 6. Sex 1		lirth 9 Day, Year) N	. Birthplace (State or Foreign Country)
Maryland B-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits
h with the	ai Direc	10e. Street and Number 10f. Zip Code 21209		10g. Citizen of What U.S.A.	at Country?
DEILIMOTE, INTELYISING Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2/10 No If Yes, specify Cuban, Mexican, Put If Yes, Specify Cuban, Mexican, Put If Yes, Specify Cuban, Mexican, Put If Yes, Specify: 1 Yes 2/10 No Specify:	(Specify Yes or Nerto Rican, etc.)	No- 14. Race - Black, Specify: [American Indian, White, etc. White
Mal yiailia 2 Lz 13-0030 d 2 should be filed within 72 hours aft lin and Manal Hygienal 27 Is marked other than "natural; or traumatic avant, the Modical Exami	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	vorking	16b. Kind of Busin	ness/Industry ity of MD
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nd 2 should I	_	19a. Informant's Name/Relationship (Type, Print) John P. Ryan (Son) 19b. Mailing Address (Street and Number or 8905 Yvonne Aven Balto,			ate, Zip Code)
DaltIMOre, bernit. Pages 1 ar Department of Hea mportant: If item any injury or other		20a. Method of Disposition **Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery, crematory or other place) 20b Place of Disposition (Name of cemetery) 20	Date /19/2010	20c. Location - Ci	
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ifficate be executed (Medical Examiner By physician and as the burial-transit as the bu	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tarry, reading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Renal Cell Covicind Due to (or as a consequence of): b. Last Fursi's to Jung Myner tension Due to (or as a consequence of): Hyner tension Due to (or as a consequence of): Hyner tension Due to (or as a consequence of):	ma		
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The law recate has bee	Completed	Brevst conun		topsy rformed? dea	ore autopsy findings available for to completion of cause of ath?
OVISION OF VIKAL INCOOLUS, P.O. BOX or Attending Physician: The law requires that the death certaffer death. Director After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Certification; To Be C	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 University	28d. Describ	sidence 6 Other e how injury occurred	
To the Hospital or Attenwithin 24 hours after deat To the Funarel Director completely filled in by the	edical Cert	29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	ice, and due to th	ne cause(s) and mann	
To the F within 24 To the F complete	Medi	29b. Signature and title of certifier 29c. License number 25c. 274		29d. Date signed (
,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAYANT HIRPARA MO 7505 OSIEN DYING		vsow p	na e
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 36202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Riefner Physician/ Month Theresa 4:00 PM october Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1408 Glenwilde Road Catonsville Baltimore 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) May 31, 1929 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 M 2 1 F Maryland **Director** 81 214-24-7934 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x☐ No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1408 Glenwilde Road 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home 12 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Assunta Terzano Samuel S. Marani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1408 Glenwilde Road Catonsville, MD 21228 Richard Riefner/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Signatur Funeral Sen State Anatomy Board 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Breast Cuncer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant a Month Year Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed 1 Yes 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by ☐ Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Raj aparnem. O D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AV-5-203, Baltimore, MD. 21209 N.S. RAJAPAKTE, M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 36203 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 8, 2010 a 10:05 PM Florence E. Roache Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sykesville Carrol1 Nursing Home Fairhaven Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Oct 21, 1 🗆 M 2 🔀 F Months Min. Year)909 NewYork Director 101 068-09-5321 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Sykesville Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 IISA 7200 Third AVenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc \$ 1 X Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 👿 No Specify: Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 civil service any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Grace Fitzgerald George S. Roache 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fairhaven Nursing Home 7200 Third Avenue Sykesville, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Call Carlinoma UF 59 vamous Physician/ (Crv1x disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 9 du lin W cementa Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 🗌 Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No Investigation Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar

State

Box 68760

P.O.

of Vital

Division

M.D s of person who completed cause of death (Item 23a) (Type, Print)

y Kes ville

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m021784

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1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene 0 | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 2:27 PM Sieglinde Rades Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🔯 Months Days Hours Min. (Month, Day, Year) ct 26, 1931 260-86-9443 Director 79 0ct Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George's MD Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 USA 7901 Annapolis Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be Baltimore, Maryland unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked or
any injury or other traumatic eve ည 3 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8118 Good Luck Road Lanham, Doctors Community Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ▼ Other (Specify) in state Euneral Stryice Licensee Ronald S Wade any in श्रीवार ^{and} Addaro तिरु^{ा।।}Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part n Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acuto myocardia Infarcher Immediate Cabse (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner leus wo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine TOVED BY MEDICAL EXAMINER requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical rae P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ s been signe should be d Records, 1 Yes 2 No 3 Probably 4 Unknown Completed analmeo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 Yes 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: ١º 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D24720 RAVINDER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEVERLY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#IperpHYS#12perFH, G909, 11/2972010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (F 2. Date of Death irst, Middle, Last) Casimir Sorosinski Physician/ NOVEMBEE 12 2010 orosinski rome Medical 4b. City, Town, or Location of Death Examiner Facility Name (if not institution, give street and number, 4c. County of Death ANNE TIMBRE WASHINGTON MEDICAL If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2 □ F Months Hours Min. (Month, Day, Year) Pennsylvania Director 183-24-2710 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at Director 1 ☐ Yes 2XX No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21122 USA 1810 Bayside Beach Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2XX Married White 1 ☐ Yes XX No Specify: Specify 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Koppers and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Casimer Sorosinski Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 1810 Bayside Beach Road Pasadena, MD 21122 / Wife Mrs. JoAnn Sorosinski injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 17 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2XXCremation 3 Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 2010 21. Signatur, of meral Sprice Licensee 22. Name and Address of Facility Singleton Funeral & Cremation PA 1 2nd Ave SW Glen Burnie, MD 21061 MO1220 Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 7EYS C disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last to the Hospital or Attending Physician. The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No ☐ Live Βιπτι ∠ ☐ , ο.... ☐ Pregnant at time of death been signed by the atte should be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ည 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D4514 MI November 12 2010 of person who completed cause of death (Item 23a) (Type, Print) D 301 Hospital Drive Glen Burnie MD 21061 31. Date filed (Month, Da 32. Regi rar's Signature State Registrar

DHMH 17 Rev 7/2009

SORDSINGE,

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Stein 12:22 AM maries Johnho OIC Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 20509 Nanticoke Road Nanticoke Wicomico Social Security Number Birthplace (State or Foreign Country)
 DE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 **X** M 2 □ F Months Days Min Hours 04/24/1926 222-14-6490 84 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Nanticoke 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20509 Nanticoke Road 21840 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Na. If Yes, Give 1944-46 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o Navy 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 KNo Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 5+ Professor of Agriculture University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Stein Ida Rassmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Stein / Spouse 20509 Nanticoke Rd., Nanticoke, MD 21840 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crem. 11/11/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Maryland Cremation Services 21203, PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physicians Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Examin the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 M No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🕱 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 27. Manner of Death
1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signa 29d. Date signed (Month, Day, Year) 11/10 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Power 21801 100 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Jovenno ar Physician/ Kandolph Silver 8:17 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 219 30 4844 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b, County 10c. City, Town or Location 10a. State Examiner must be notified at Completed by Funeral Director Baltimore MD 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number o 2120 USA 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò 1 Yes 2 No Specify: Maryland 21215-0036 Black Specify: 3 Widowed 4 Divorced Year or Dates th and Mental Hyglene. 27 is marked other than "natur traumatic event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) per (Be Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) ဂ 19b. Mailing Address (Street and Number or Qural Route Number, City or Town, State, Zip Code) 9a. Informant/s Name/Relationship (Type, Print) Kobinson Health a Department of Health Important: If item 27 any injury or other tr altimore, 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kandalstown, MD 21. Signature f Funeral Service I censed Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Sncer Ph_sician/ disease or condition Medical resulting in death) Due to (or as a conse plance of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 attending pl IE FEMALE: Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi November 14, 2010 18927 Resident Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. President St. Unit 1504 Baltimore, MD Vora 675 Milan 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER 523 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 05 (trm 0 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 XM 2 □ F -74-160 **Director** Usual Residence of Decedent or 28a-f shov 10a . State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No HIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Valle Funeral "natural", or items 23a 21202 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: 3 Divorced 4 Divorced HMERICAN Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than any injury or other transmitted. Elementary/Seconday (0-12) College (1-4 or 5+) tailer 4/timore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ t's Name/Relationship (Type, Print) a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 1 A Burial 2 Cremation 3 Removal from State 160.172010 4 ☐ Donation 5 ☐ Other (Specify) RMOTIAL bod ANN MAR 22. Name and Address of Facility re of Funeral Service Lenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of figart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician, Medical resulting in death) Due to (or as a **Examiner** 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last 2 weeks the Hospital or Attending Physician: The law requires that the death certificate be executed tunaenna attending physician and for use as the burial-tran Due to (or a a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 (Check Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) AT- 243 8946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEHA KALA 201 E UNIVERS BALTIMORE. MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 5:30 PM TOLIAFEKRO NOUSHBYL 16 ZOIU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balli More 9. Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Months Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notifled at MD 1 Yes 2 No taltimore. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Venue 21212 items 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If item 27 Is marked other than Disablee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 0 other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 916 Department of Health a Important: If item 27 Is any injury or other trainonce. Avenue terro Dr. Conther 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 2 ☐Cremation 4 Donation 5 ☐ Other (Specify) 21. Sgnature of Funeral Service Li and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 7 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No MAGIA 24a. Was an autopsy perform certificate 2 No Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mayner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital or 🗗 😂 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 R088852 CRNI

Registrar
DHMH 17 Rev 1/2001

State

2835 Smith DUSNUL

SOUTHBUE MANY/DUS 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

32. Registr

KATULSSN C. DIAMONS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Twining III John Isaac November 16, 2010 Physician/ 10:30 a M Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Glen Arm 5629 Sharon Drive 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 217–36–4276 **Funeral** Month, Day, ^{Year)} 1938 Days Min 1 ፟ M 2 □ F Months Hours Feb MD Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City. Town or Location 10d. Inside City Limits 10a, State Director Glen Arm Baltimore MD 1 ☐ Yes 2 🄀 No 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 21057 5629 Sharon Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married à Specify: White 21215-0036 1 ☐ Yes 2X No Specify: Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Laudenklaus ပ Isaac John Twining Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5629 Sharon Drive, Glen Arm, MD 21057 Martha C. Twining/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 11/18/2010 Final Journey Crem. Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 108 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 KNo 3 Probably 4 Unknown Records. 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Yes 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: **X**Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BADMONE, MB 21204 CHAMIT IT. 32. Regist State Registrar

			For State	State of I	Maryland		artment of F		and M	lental Hy	- 9	2010	3621	-
			Registrar 1. Decedent's Name (First, Middle	, Last)		001	incate or L	Jean		2. Date of De	Reg. No	-010	3. Time of Death	-
	Physicia Media		Evelyn L.	Van Dyke						$\overset{Month}{11}$	Day 16	2 ^{Year} 2010		
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-			Genesis Elder				Sever					Anne A	undel	
	Funeral		5. Social Security Number	6. Sex 1 M 2 XF	Age (In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da 7/4/1		g. Birt Co	hplace (State or Forei	ign
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Hosp	within 24 nours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical E	Physician: To the best xaminer: On the basis o	f examination a	and/or investi	gation, in my opinio	n, death oc	curred at t	the time, date a	nd place, a	and due to the c	ause(s) and manner sta	ated
Fo the	митліп Fo the	Σ	only one), 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	ie best of my k	rnowleage, a	29c. License		and place			gigned (Month		
			Hux I Va	ing MO			DS	-311	1		11,	17/2		
			30. Name and address of person v	vho completed cause of	death (Item 2	3a) (Type, P	rint) , ,	1 4	A	Die C	20.	A 2 /		_
			30. Name/and attdress of person v HUNG PANS; 2	007 TIDEL	JATEN2		ony 1-1	+, 141	シャンナケ	UCN	ivn	0 21	70/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RENEC 3:24 PM VETT NOV Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COUNTY CONDUM (DWARD HOZPITAZ COLUMBIA Honn-RD Social Security Number Birthplace (State or Foreign Country)
 CERMANY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 76-30-478 1 M 2 X F Days Hours 1^M7^m7^m1^m30 **Director GERMANY** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10625 HICKORY CREST LANE 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 💢 No If Yes, Give δ 1 Never Married 2 Married Maryland-21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced WHITE Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) JEWISH AGENCY Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT FOR ISRAEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental E. VEIT **ERNA** HAMMEL Lege 1 and 2 shu Legertment of Health and Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10625 HICKORY CREST LANE, COLUMBIA, MD ANDRE WEISS/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) COLUMBIA MEMORIAL PK: 11/16/2010 COLUMBIA, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SEPTIL SHOW Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner GERRY PERLITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury IMS Examine Due to (or as a consequence of) and -transit PERFORMED COSON The law requires that the death certificate be executed 516muss) HRC that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown the P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Corronary AUTERY nycopyo Completed 1 ☐ Yes 2 ☐ WO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? My PERTENZIUM 24a. Was an s certificate has b director, page 2 s[|] autopsy 1 Yes 2 No 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 036974 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 CHARTER MS 21544 DAVID NYMITOM F 310 Corongist 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of State of Registrar	Marylan		artment of He tificate of De			Jiene Reg. No.	10 36213
	Physicia		1. Decedent's Name (First, Middle, Last) Lynette Sharon Walker 2. Date of Death Month Day Year Novembre 11, 2017							
-	Medic Examin							NOACIII	4c. County	
	Funeral Director			7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country) MD
		'n	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	eation	1	3/29/1	956	10d. Inside City Limits
	Maryla 28a-f s totified	Director	MD	Bal	ltimoı					1 ☐ Yes 2 ☐ No
	with the is 23a or	Funeral D	10e. Street and Number 2814 Lake Ave			10f. Zip Code 21213			10g. Citizen of W US	/hat Country?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ठ्व	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Deced Armed Force 1 Yes 1f Yes, Give Year or Dat	es? 2 X No	It	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 🙀 No	Mexican, Puerto F	cify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. Black
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ıland	d be filed Jental H Irked ot tic ever		17. Father's Name (<i>First, Middle, Last)</i> James David Glover			1	8. Mother's Name Willie		,)
, Maryland 21215-0036	id 2 should salth and M n 27 is ma er trauma	100	19a. Informant's Name/Relationship (Type, Print) Si Annette Cox	ster	19b. Mailin 2810	g Address (Street and Evergree	d Number or Rural	Route Number, Baltim	City or Town, St.	rate, Zip Code) D 21217
Baltimore,	Page 1 arment of He tant: If iten		20a. Method of Disposition ★☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	State Co		sition (Name of natory or other place) armel		o/10	20c. Location - C Baltimo	City or Town, State Ore, MD
Balt	permit. Depart Import any inj	1 1	21. Signature of Funeral Service Licensee	100		Name and Address	of Facility .iver ^P St	illip / Bali	A Weath	nerford MD 21213
_	enysician/ Medical	30	23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause in each immediate Cause (Final disease or condition esulting in death)	n line.	fz	r the mode of dying,		respiratory arre	st,	Approximate Interval Between Onset and Death The
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68760	ertificate ding phy se as the		IF FEMALE: 23c. If yes, outcome	ome of pregnal	nev			- 18		
). Box 68	the death or by the attenuached for us	Physician/M	in the past 12 months?	irth 2 D Fetal ant at time of d	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery hth Day Year
Division of Vital Records, P.O.	s tha	δ	Part II. Other significant conditions contributing to dea	th but not resu	ulting in the ur	nderlying cause given	in Part I.			bute to the cause of death? 3 □ Probably 4
Recol	Physician: The law re r this certificate has be rral director, page 2 sh	Completed						24a. Was ar autops perform 1 \(\subsection \text{Yes} \) 2	y pr ned? de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Vital	ysician iis certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 MNo Hospital: 1 ☐ In	patient 2 🗆 I	ER/Outpatient	Other	e of Death (Check		nce 6 XOther	(Specify) Co Sala
on of	nding PP ath. r: After th ie funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, 2 Accident Investigation	injury Day, Year)	28b. Time of injury	28c. Injury at work? M 1 □ Ye			w injury occurred	
Divisio	al or Atte s after de I Directo d in by th			f Injury - At hor , etc. (Specify)		et, factory, office	2	8f. Location (Str City or Town		or Rural Route Number,
27. Manner of Death 1								he time, date and	d place, and due t	to the cause(s) and manner stated.
	Tot with Tot com		29b. Signature and title of certifier			29c. License nu	S30	2	Ovember	(Month, Day, Year) V ZUIO
			30. Name and address of person who completed cause	of death (Item	23a) (Type, Pr		mas i	ST Por	1 1002	20
	Stat Registra		31. Date filed (Month, Day, Year) 37. Reg	istrar's Signat	e pa	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 Year Donnell Wagner Nov. 11 7:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Future Care Baltimore 8. Date of Birth (Month, Day, Year) 0 3 / 0 5 / 1 9 5 7 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ MM 2 □ F Months Days Hours Min 53 216-68-4879 Director Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. MD 1√2 Yes 2 □ No Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5504 Knell Avenue 21206 Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Floor Care Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miles Wagner Ruth Hunt မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Wagner (Wife) 5504 Knell Avenue, Baltimore MD 21206 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel Cem. 11/19/2010 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A. Weatherford F.S. 21. Signature of Funeral Service Licensee 2431 E. Oliver St, Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Diabetes Mellitus Type 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? After this certificate funeral director, page 1 ☐Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4♥ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ∐Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural death. ieral Director: A 1 Tes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jonathan Rich, 🔥 🔊

31. Date filed (Month Day, Year)

H0062638

301 St. Paul Place, Suite 409, Baltimore MD 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ance 746A M November 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore of Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 № M 2 🗆 F Months Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland 1 Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 4205 Fairy Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edlow Mattie Mickey ancer ဥ 19a. Informant's Name/Relationsh (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 lances Fairfax Kd. Baltimore Marylan Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State DUNSVIlle 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx mate Interval Between Onset and Death Immediate Cause (Final **Physician** Myscardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of yptral or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burnal through attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? (es 2 12 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 Accident 2 □No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier November 14,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick mc Ginley Sinai M, D, 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 182010 Registrar

DHMH 17 Rev 1/2001

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Reginald Allnutt 2010 November 6:42A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19321 Frenchton Place Montgomery Village Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 11 **Funeral** 9. Birthplace (State or Foreign Year) 1930 Washington, D.C 1 XM 2 □ F Days Director 578-42-4239 79 Nov. Usual Residence of Decedent show 10a. State Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d, Inside City Limits 28a-f 1 Yes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 19321 Frenchton Place 20886 U.S.A. items death \ 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No . or Black, White, etc þ 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give "natural", Specify: White 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Transportation Supervisor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည should be Reginald C. Allnutt Edna Warfel of Health and Mitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20886\,$ A. Lynn Allnutt - Wife Page 1 and 2 19321 Frenchton Place, Montgomery Village, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Ponetion 5 ☐ Other (Specify) Metropolitan Crematorium 11/03/10 Alexandria, Virginia Signature of Funeral Service Cense 22. Name and Address of Facility
Molesworth-Williams P.A., Fu
26401 Ridge Road, Damascus, Funeral Homeus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 18 months Immediate Cause (Final Ph sician/ disease or condition resulting in death) Small Cell Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or impury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by X☐ Yes 2☐ No 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has t autopsy after death.

Director: After this certificate! performe death? 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital. 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work 2 Accident
3 Suicide
4 Homicide Investigation 1 Tyes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practicum: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and due to the cause(s) and manner as stated. (Check To the within 2 at the time, datu and place, and due to the caucate) and manner as etate 29b. Signature and title of certifier 29c. License number roseph m. Harzerty mo November 3, 2010 D32407 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Joseph M. Haggerty,

31. Date filed (Month, Day, Year,

571VA

DHMH 17 Rev 7/2009

9707 Medical Center Dr., Rockville, Maryland

M.D.

32. Regis var's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State	State of Maryland	d / Department	of Health and N	∕lental Hyo	giene	
	1 = State Registrar		Certificate	of Death	F	Reg. No 2 0 1 0	36217
Physician	Decedent's Name (First, Middle, Last) Tanna Tanna				2. Date of Dea Month	Day Year	3. Time of Death
/Medical		Ann	Adki		CCTODE		
Examiner			4b. City, lo	own, or Location of Death	-	4c. County of Death	3
-3	5. Social Security Number 6. Sex	nov	ast birthday) If Under 1	icess itnin	e	Somers	
Funeral	10	M 2 🖾 F		Year If Under 24 Hrs. Days Hours Min.	8. Date of Birtl (Month, Day	y, Year) 9. Birth	place (State or Foreign ntry)
Director	Usual Residence of Decedent	69	113.		6-1-194	41 <u>Del</u>	aware
and	10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
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with 1	10e. Street and Number		10f. Zip C	ode		10g. Citizen of What Coul	itry?
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er de	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	. 13. Was Deceder If Yes, specify	nt of Hispanic Origin? (Sp / Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
036 urs aff alr., or	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ No If Yes, Give	1 □ Yes 2 1	No Specify:		Specify: Wh	nite
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, it a Medical Evament must be maithed at Be Completed by Funeral Director.	3 Vidowed 4 Divorced	Year or Dates:	10- 5				
21215-00 ed within 72 hou ygiene. Per than "nature to the Marchelle to the Marchelle to Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Decedent's Usual ((Give kind of work)	Occupation done during most of worki retired)	ing	16b. Kind of Business/In	dustry
withi ene.	Elementary/Secondary (0-12)	College (1-4or 5+)				0 77	
d 2	17. Father's Name (First, Middle, Last)		Homemake	18. Mother's Name	(First Middle	Own Home	
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ryla hould I de Men marke matic e To	19a. Informant's Name/Relationship (Type	T.	Steele	Virginia		Sparpaglione	
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altimore, Marylamir. Pages 1 and 2 should partment of Health and Me partment of Health and Me portnert: if item 27 is mark injury or other traumatings.	Gerald Adkins - Hu 20a. Method of Disposition		32581 Mount ace of Disposition (Name	t Hermon Roa	d, Pars	onsburg, Man 20c. Location - City or To	cyland
O or of or	1 X Burial 2 ☐ Cremation 3 ☐ Re		metery, crematory or othe	er place)	Jale	20c. Location - City of Te	wn, State
tr Printing	4 ☐ Donation 5 ☐ Other (Specify)		est Grove Ce	emetery 11-	1-2010P	arsonsburg.	Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evernet parameter of the any injury or other traumatic event, the Medical Evernet must be notified at once.	21. Signature of Funeral Service Licenses	0 00	22. Name and			uneral Home	
- 40260	lenvo fel	lytarkin	705 E. N	<u>Main Street,</u>	Salisb	ury, Marylan	nd 21804
3	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the death.	Do not enter the mode of	of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
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e exe	resulting in death) Last	Due to (or as a conseque	ence of):				
68760 tificate be eg physician as the burieledical Election	d.						
	IS SSAALS						
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dea de att sed for sicile	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of dea				Month	Day Year
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ds, P.O. I direct that the de signed by the a d be detached to dby Physic dby Physic	Part II. Other significant conditions contr	ributing to death but not result	ing in the underlying caus	se given in Part I.	23e. Did tol	bacco use contribute to the	ne cause of death?
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of Vital Re Physician: The le rail director, page 2	examiner? .	spital: 1 Innationt 2 F	R/Outpatient 3 DOA	Other:			
Division of Vital or Attending Physician: 1 after death. Director: After this certification by the funeral director, pure retrification: To Be Coertification: To Be Coertification: To Be Coertification: To Be Coertification	27. Manner of Death	28a. Date of Injury 2				ence 6 Other (Specification)	/)
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Divisio Divisio al or Attendi s after death. In Director: A ed in by the fu	4 Homicide determined	building, etc.*(Specify)		- 1	City or Town	n, State)	,
spitz nours nera / fille	29a. Certifier 1 Certifying Physic	cian: To the best of my knowl	edge, death occurred at t	the time, date and place.	and due to the c	ause(s) and manner as s	stated.
Div To the Hospital or vivilin 24 hours after To the Funeral Direct Completely filled in E.	(Check only 2 Medical Examine one)	r: On the basis of examination and manner stated.	on and/or investigation, in	my opinion, death occurr	ed at the time, d	ate and place, and due to	the cause(s)
To the vithing of the somp	29b. Signature and title of certifier		29c. Li	icense number	2	9d. Date signed (Month,	Day, Year)
	Donn	Agrel -		D68222		10-29-1	
	30. Name and address of person who com	pleted cause of death (Hom 5	(2a) (Time Print)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraMEND#19aperFH,11/9/10,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/29/2010 Margaret E. Ames Medical 8:45p. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Bethesda Bethesda Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. Illinois **Director** 159 01 9174 Yrs 11/01/1912 97 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho.

ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5415 Connecticut Ave, NW # 209 20015 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married δ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Department of Commerce Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Millard E. Ames ဂ္ Mary Whitaker 19a Informant's Name/Relationship (Type, Print) Jane Kelly --Niece Jane Kelly/cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Jane 13 Whitman Ave., Lindenwold, NJ 08021 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/03/2010 Falls Church, Virginia National Crematory . Signature of Funeral Servi 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wiscinsin Ave, NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ONCES HEARI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
 5 ☐ Other (specify) __ Pregnant at time of death Month Day ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 🗷 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 KNo Other: ၉ in 24 hours after death.

the Funeral Director: After this of a political political directions and a political directions. 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10130110 D0057124 sero (on)

State Registrar 31. Date filed (Month,

NOV 02

Truong Bao, M.D. 10110 Molecular Dr., Suite 206, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#10f+19bper INF, 11/12/10, BW Settificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 10731/2018 FRED BERNARD ALEXANDER, JR. 7:37 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12308 Chagall Drive North Potomac Montgamery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 0/20/1948 Director 437-68-7181 62 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery North Potomac 10e. Street and Number ò 10f Zip Code 20878 10g. Citizen of What Country? er than "natural", or items 23a o Funeral 12308 Chagall Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Ayes 2 No 1970-Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 1975 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Financial Planner Protective Life Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked Fred B. Alexander, Sr. Clara Joubert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin 600) 19a. Informant's Name/Relationship (Type, Print) Joyce Alexander - wife 12308 Chagall Drive, North Potomac, MD 20 Baltimore, injury or other Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from netery, crematory or other place, Parklawn Memorial Pk 11/06/10 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a Part 1. Enter the dise ations that caused the d cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or comple shock, or heart failure Interval Between Immediate Cause (Final set and Death CO (4 aucer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) e attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Tes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title o 10 30. Name and addre ho completed cause of death (Item 23a) (Type, Print) 707 Meduci

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Division of	or Attendii Iter death. Iirector: A n by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm (Specify)	n. street, factory, office		8f. Location (Street City or Town, St.		ural Route Number,
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	o the Point 24 of the Formpleto	Med	one) and manner state 29b. Signature and title of certifier	ed.	29c. Licensi			Date signed (Mont	
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a special	J. J.		30. Name and address of person who completed cause of deal Claudia O Arumala DHHC P	th (Item 23a) (Ty	ype, Print) Sellisb	ury mb	21802-	2018	
į.	Sta Registr		30. Name and address of person who completed cause of dea Claudia O. Arumala. DHHC, D. 31. Date filed (Month, Day, Year) NOV 0.3 2010	s Signature	bake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMBUSH Physician/ EDWARD CHARLES 2010 8:06 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOLDEN LIVING CENTER FREDERICK FREDERICR Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, 215-20-7603 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director FREDERICK PREDERICR MO. 1

Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number CASTLE Funeral US NEW 21702 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ✓ Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED 12 774 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ AMBUSH AMB USH 00 C BESSIE injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNEDY (clau) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau NEW CASTLE COURT FREDERICK MO MONETTE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State QCT. 25, 2010 FREDERICK, MB. PAIRVION COM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. HOME 21. Signature of Funeral Service Licens FREDERICK MO 21701 110 WEST SOURT SF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Anteny oneumy Physician/ Lenosis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed; 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 1 🗌 Yes 2 L မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 To the P only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 10-22-2010. 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK. HO Toll House AUE -814 7 BTE A-KAZMI. MO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, I	Last)		er till Cate Of L	Jealii	2. Date of Deat	leg. No.	3. Time of Death
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80°	dearn ne att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify)		×**	Mo	onth Day Year
o i	If the	Phy	Part II. Other significant condition	s contributing to death bu	ut not resulting in th	e underlying cause gi	ven in Part I.	23e Did to	hacco use contr	ribute to the cause of death?
υ, Έ	es tha	l by	Tarris Other organization	o commoning to document		3				3 Probably 4 Unknown
rds	requir	etec						24a. Was a	n 24h)	Were autopsy findings available
၁၁	has law	Completed				1		autop: perfor 1 \subseteq Yes	sv I	prior to completion of cause of death?
ř	n: In: ificate or, pa		25. Was case referred to medical			26 P	lace of Death (Chec		2 No '	1 Yes 2 No
/ita	/sicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 ER/Outpa	Oth	er:	ome 5 Reside	ence 6 \(\text{Other}	er (Specify)
of	g Phy er this neral c		27. Manner of Death	28a. Date of injur	y 28b. Time	of 28c, Injur	y at	28d. Describe ho		
on	endin sath. or: Aft he fur	fical	1 Natural 5 Pending 2 Accident Investiga	ition	, rear, and		Yes 2 No			
NISI	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: Herr this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (St City or Town		er or Rural Route Number,
	pital o		29a. Certifier 1 Certifying F	Physician: To the best of	my knowladgo doo	th accurad at the time	data and place a	and due to the cou	ee(e) and mann	par as stated
;	24 hc 24 hc Fun	ledical	(Check 2 Medical Ex	aminer: On the best of ex Nurse Practioner: To the b	kamination and/or in	estigation, in my opini	on, death occurred a	at the time, date ar	nd place, and due	e to the cause(s) and manner stated.
	To the within To the Comp	Σ	29b. Signature and title of certifier			29c. Licens				d (Month, Day, Year)
			Me.	MD		Do	60417		11-1	-2010
			30. Name and address of person w		eath (Item 23a) (Typ	e, Print)	. 1/	· ·	3	
	2		Hemen She	14, 656		as johns	ion Dr	trec	levierc	MD 21702
	Stat Registra		31. Date filed (Month, Day, Year)	4 2010 ^{32. Registra}	r's Signature	parke				
			1401							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36223 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 29, 2010 Physician/ Mittie Rucker Buchanan 6:25 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 514 Shelfar Place Fort Washington 7. Age (In yrs. last birthday) Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XXF Hours May 2 1938 Washington DC 72 Director 579 52 6357 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Fort Washington 1 Yes 2 XXIo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 514 Shelfar Place 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status rmed Forces?

Yes 2 XXVo Black, White, etc. 1 Never Married 2 Married δ If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify: Specify: Black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Census Bareau Statician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Rucker, Sr. Hattie Elizabeth Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M Buchanan, Sr (Husband) 514 Shelfar Place, Fort Washington, MD 20744 20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cedar Hill Cemetery Nov 5, 2010 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Jul 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria M01140 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastases Physician/ Brain disease or condition Medical resulting in death) Due to (or as a consequence of) 1 mon Th **Examiner** - Small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ venous Thromboses em to/is ano pulmonary 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate has page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 1 ☐ Yes 2.X No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 \square Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1. 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD - D0068056

Registrar

31. Date filed (Month,

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Kaser

Permanente. 1221 Mercantile La, largo,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

fattenroth

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Norma Frances Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico isburg sburu Rehabilitation & Nursing Ctr If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Min. Hours 05%5771927 83 Maryland 218-20-8232 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Wicomico Salisbury 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21801 USA 200 Civic Ave. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 'n, þ 1 Never Married 2 Married Yes 2 X No パピトペパム してひഡり Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify If Yes, Give Year or Dates and Mental Hygiene. Completed 3 X Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salisbury University 12 administrative aide other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frances Eliza Parker Howard Edward Murrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 905 Moonstone Circle, Salisbury, MD 21804 permit. Page 1 and 2 sh Department of Health ar Imp. rtant: If item 27 is any njury or other trau Jane Ellen Brown/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Donation 5 - Other (Specify) 11/01/2010 Salisbury Crematory Salisbury, MD Holloway Funeral Home Professional Association ouo 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that proved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Cance Onset and Death Physician/ disease or condition year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed death? this certificate 2 🗌 No Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other 1 Yes 2 6 100 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t Natural 5 Pending 2 🗌 No Investigation Could not be the Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 □ Certifying Nurse Fractioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year,

MID

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM BRUNORI S. October 2010 4:15 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING & REHAB CENTER WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. JAN. I, 1918 1 🕅 M 2 🗆 F Months Hours PENNSYLVANIA **Director** 203-03-4654 92 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits or 28a-f 1 ☐ Yes 2 🛣 No MARYLAND WORCESTER BERLIN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 180 OCEAN PARKWAY 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: WHITE Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) William CARPENTER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BRUNORI BRIDGET **GILARDI** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOMINICK BRUNORI/SON 11119 ADKINS RD., BERLIN, MARYLAND 21811 Brunori, Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SHADY LANE CEMETERY 11/5/10 CHINCHILLA, PA Sig vature ice L cense 22. Name and Address of Facility 19975 HASTINGS FUNERAL HOME, SELBYVILLE, DE 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Theimers dementin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires mat within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မှ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pennie Savage,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Registrar's Signature,

29c. License number

9715 Healthway Dr, Berlin,

R 135131

29d. Date signed (Month, Day, Year) November 1,

21811

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 70/58%5070 12:37 PM Michele Ruth Branson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Days Hours Months *05708719*64 Director 213-88-1040 Usual Residence of Deceden 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Prince George's MD 1 X Yes 2 No Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7212 Abbington Dr. 20745 AZU "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Executive Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nathaniel H. Alexander, Jr. Bethesda L. Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16805 Dorchester Pl., Upper Marlboro, MD 20772 Sonja Maclin / sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Resurrection Cemetery 11/04/2010 Clinton, MD Signature f Funeral 3 ce 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or imjury that initiated events and resulting in death) Last Due to (or as a conseque been signed by the attending physician should be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed certificate 1 Yes 2 No After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30, Name and address of ersen who completed cause of death (Item 23a) (Type, Print) e filed (Month, Day, Year) NOV 0 5 2010 32. Registrar State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 Sernaro 9600 2010 . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death riendsu. iendsu arre Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **□**xM 2 □ F Days Months Min. 4/4/1954 Hours West Virgini Yrs Director 56 218-64-9165 Usual Residence of Decedent or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2806 Friendsville RD 21531 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes. Give 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment. Important if item 27 is marken any injury or Clyde Mervin Bernard Mariorie В. Frazee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21531 Clyde K. Bernard/ Brother 2806 Friendsville RD, Friendsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery 11/1/2010 Oakland, Maryland Sig vare of Juneral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 179 Miller St., Grantsville, 21536 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Arterioa disease or condition resulting in death) Ray Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ending physician a use as the burial-Physician/Medical Box 68760 attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 g Unknown signed by the a d be detached for 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 \(\) autopsy performed? Yes No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, 701 O

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30, 2010 3:45 P^{M} October Laura Bittinger Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Year)
April 17, 1922 Pennsylvania If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. Months 1 □ M 2 1 F 88 Director 204-16-9884 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examination in the restrict and the amone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director PA Somerset Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15558 USA 112 Washington Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Bittinger Bertha Folk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Pittsburgh Ave., Mtn. Lake Park, MD 21550 Nick B. Brown/Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Country Side Crematory Nov. 1, 2010 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Home, Inc. 21. Signature of Funeral Service Licenses Lyur P.O. Box 116, Salisbury, PA emale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ncumonia /Medical ue to (or as a consequence of): Examiner DEMENTIA ALEITEIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar NOV - 1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Berlin Seymour 2010 11:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Riderwood Independent Living Silver Spring 9. Birthplace (State or Foreign Country) Ohio 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Augonth, Pay, Y14917 1 € M 2 🗆 F Months Hours 93 294-09-0980 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director Silver Spring 1X Yes 2 No Montgomery MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? P Funeral 238 3158 Gracefield Road #414 20904 USA or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces rces? 2 □ No 1843 Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Administration U.S. Govenment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Marie Rutsky David Berlin 20904 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 3158 Gracefield Road #414, Silver Spring, Maryland Edith Berlin/Wife Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State Judean Memorial Grds. 11/1/2010 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitEdward Sagel Funeral Direction, Inc 1091 Rockville Pike, Rockville, Maryland 20852 Blake Kurt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 Months Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and I for use as the burial-trensit requires that the death certificate be executed Esophageal Cancer that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Yea Pregnant at time of death 5 Other (specify) the g ... Unknown n signed by the detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s Hypertension autopsy performed' 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 29, 2010 D59524 uman 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Loveen J. Puthumana,

31. Date filed (Month, Day, Year) **NOV 02 2010**

Registrar's Signature

3110 Gracefield Road, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year REBECCA ELIZABETH BOWERS 8:10A M OCTOBER 29 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 KF March Day (ear) Days Hours Min 1930 215-26-8769 80 Mary land **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1610 Rock Creek Drive Apt. 2 21702 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 3 Maryland 21215-0036 1 ☐ Yes 2 No Specify. Il Hygiene. other than "natural", If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be fill f Health and Mental item 27 is marked Joseph Edward Elkins, Sr. Rebecca Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Bowers, Jr. / Husband Department of Health Important: If item 2 any injury or other t 1610 Rock Creek Drive Apt. 2, Frederick, MD 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 10/30/2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Lights ROBERT^{an}t de Tarie & SON FUNERAL HOMES, P.A. 201 NORTH MARKET STREET, FREDERICK, MD 21701 pato 23a. Part 1. Enter the disease, or complications the caused the shock, or heart failure. List only one cause in each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ lood disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, cause (Disease or linjury obstructive burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be as the k IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No Hospital or Attending Physician: The certificate 2 🖭 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 24 hours after death.

Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Priystolati. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Records,

Division of Vital

MI

Syed W. Haque, MD, 700 Montclaire Avenue, Frederick, MD 21701

32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October FLORENCE SMITH 2010 9:28 P^{M} BRYSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. July 13 Year 1926 Pennsylvania 1 M 2 F Hours 207-16-6799 84 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Exa</u>miner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛢 No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12327 Sherwood Forest Drive 21771 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Homemaker 0wn Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Florence Barton Smith John E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12327 Sherwood Forest Drive, Mount Airy, MD 21771 Barbara L. Conlon/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Park Lawn
Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oct.30,2010 Rockville, Maryland Signature of Funeral Service License 22 Name and Address of Facility Molesworth—Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) preumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The law page 2 has certificate 2 No 1 Tes of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending Division 1 🗆 Yes 2 🗆 No within 24 hours after death. To the Funeral Director: A Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe e and address of person who completed cause of death (Item 23a) (Type, Print) rant Street Frederick, MD 31701

DHMH 17 Rev 7/2009

State

Registrar

-32. Registrar's Signature

9

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	e Type or Print in				_		_	
	•	For State Registrar	State of Maryla		artment of F tificate of L			Reg. No.	211111	36232
Physicia		1. Decedent's Name (First, Middle, La SARAH WHITE B	,				2. Date of De		^y 201 0 ^{ear}	3. Time of Death 8:30 P M
Medic Examin		4a. Facility Name (if not institution, giv	re street and number)	•	4b. City, Town, or	Location of Death		$\overline{}$	County of Death	
		6028 DICKERSO 5. Social Security Number 6.		land hindhadaya	DICKER If Under 1 Year	SON If Under 24 Hrs.	La Dun d'El		REDERI	
Funeral Director		578-34-4299	Sex 7. Age (In yrs. 1 M 2 F 85	Yrs.	Months Days	Hours Min.	8. Date of Birl 1 0 7 0 4	7492	2.5 g. Birt	hplace (State or Foreign Intry) MD
faryland Ba-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD FRED	ERICK 10c. C	ity, Town or Loc						10d. Inside City Limits
ith the N 23a or 2 st be no		10e. Street and Number 6028 DICKERSO	M BOAD		10f. Zip Code 2084	2			izen of What Co	untry?
after death w I", or items ' xaminer mus	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White Specify: WH	, etc.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest g	Year or Dates. Education rade completed) College (1-4 or 5+)	(Give k	lent's Usual Occup kind of work done of D NOT use retired)		king	16b. Ki	ind of Business I	industry
be filed wit lental Hygie rked other tic event, th	To Be C	17. Father's Name (First, Middle, Last, BENJAMIN WHIT		ноо	SEWIFE	18. Mother's Nar	me (First, Middle,	Maiden S	OMESTIC Surname)	<u>. </u>
2 should th and M 27 is mai traumat		19a. Informant's Name/Relationship (g Address (Street a					
Page 1 and lent of Heal nt: If item : ry or other		20a. Method of Disposition 1	Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other place	re)	Date	20c. Lo	ocation - City or	
permit. F Departm Importa any inju		21. Signature of Funeral Service Lice	1	22	. Name and Addres	ss of Facility	P	.0.	BOX 86	5
Physician/ Medical		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	age	r the mode of dyin	^		rest,		Approximate Interval Between Onset and Death
Examiner	'n	Sequentially list conditions,	Due to (or as a consect	fi bi	allation	ù				
executed n and al-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linijury that initiated events resulting in death) Last	c. Due to (or as a consec	hy0010	lism					
cate be cate by cate be cate by cate be cate by cate b	edical		d							
To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician a completed filled in by the funeral director, page 2 should be detached for use as the burial-	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🂢 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fei 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnand Other (specify)	sy			23d. Date of deli Month	ivery Day Year
quires that the series of signed by all the detact	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.				the cause of death?
: The law rec cate has be page 2 sho	Completed						24a. Was autor perfo 1 Yes	osy ormed?	prior to death?	opsy findings available completion of cause of
sician: certifi rector) Be	25. Was case referred to medical examiner? 1 ☐ Yes _ 2 📉 No	Hospital:	1	Othe	ace of Death (Che	1			
g Physer this er this eral di	:e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	t 3 🗆 DOA 28c. Injury	4 □ Nursing F / at	lome 5 X Resid		-	f(y)
tending eath. or: Aft the fun	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not	he	injury		? Yes 2 \(\subseteq No				
intal or Att urs after d ral Direct lled in by		4 Homicide determined	building, etc. (Specif	(y)			City or Tow	vn, State)		al Route Number,
e Hosp 124 ho e Fune eleted fi	Medical	(Check 2 Medical Exam	ysician: To the best of my knov niner: On the basis of examination rse Practioner: To the best of n	on and/or invest	igation, in my opinio	on, death occurred	at the time, date a	and place,	, and due to the c	ause(s) and manner stated
To the within comp	-	29b. Signature and title of certifier	Nag		29c. License	5506 \		29d. Dat	te signed (Month	Day, Year) B, 2010 D 21701
5		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, P	WEST N	INTH ST	FIFE	DG2	ick, Mi	0 21701
Stat Registra		31. Date filed (Month, Day, Year) 0CT 25	9 20 0 Register's Signa	ature A.	parke				- <i>†</i>	

Registrar DHMH 17 Rev 7/2009

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		For State		State of N	/larylar		artment of H		Mental Hy	giene	In	36233
		Registrar 1. Decedent's Name	e (First, Middle,	Last)		Cei	rtificate of E	Death	2. Date of Dea	Reg. No.	10	3. Time of Death
Physicia Medic			Ger	ald Richa	rd C	lark			Month Novem	D	Year 2010	
Examin		4a. Facility Name (if	not institution, g	give street and number)			4b. City, Town, or	Location of Death		4c. County	y of Death	
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be file ental H ked of c ever	TO B	17. Father's Name (F		st)				18. Mother's Nam			e)	
hould and Mi is mar tumati		19a. Informant's Na		(Type, Print)		19b. Mailir	ng Address (Street a	*			State, Zip	Code) 20906
and 2 s Health sm 27 her tra		Judith A		k - Wife				re World	Blvd. #			Spring, Md
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me Ical Examiner must be notified at once.			Cremation 3	Removal from Stat		emetery, crer	sition (Name of natory or other place ce Method	e)	Date	20c. Location	•	
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es that signed be de	by	Part II. Other signifi	icant condition	s contributing to death	but not res	ulting in the u	inderlying cause give	en in Part I.				he cause of death?
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r Atter ter dea irector	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be 28e. Place of In	jury - At ho tc. (Specify		eet, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
pital o	cal C	29a, Certifier 1.	X Cortifying P	hysician: To the best of			accurred at the time	data and place or		. ,		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	☐ Medical Exa	aminer: On the basis of lurse Practioner: To th	examinatior	n and/or invest	ligation, in my opinio	n, death occurred a	t the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
To the within to the comment		29b. Signature and t		*	and the state of	The same and the s	29c. License	number		29d. Date signe	d (Month,	Day, Year)
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Registra MH 17 Rev 7/20			NOV	4 2010 ▶ ८	eneva	p.	4 answ			-		· <u>-</u> -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAMES WILLIAM CLARK, JR. NOVEMBER T. 2010 8:38 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES CIVISTA MEDICAL CENTER LA PLATA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Months 220-16-7363 1 XM 2 1 F 82 Hours Min. AUGUST 1, 1928 MARYLAND Director Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f MARYLAND CHARLES BRYANS ROAD 1 Yes 2X No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2842 MARSHALL HALL ROAD 20616 UNITED STATES within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1948If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced BLACK 1952 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 1 YEAR College (1-4 or 5+) ELECTRICIAN FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of is marked of Department of Health and Ments Important: If item 27 is marked any injury or all JAMES WILLIAM CLARK, SR. pe EVA ELNORA KEY CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDNA C. CLARK / WIFE 2842 MARSHALL HALL ROAD, BRYANS ROAD, MARYLAND 20616 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State METROPOLITAN CHURCH CEMETERY NOV. 6,2010 INDIAN HEAD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice in THURNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-transit and Due to (or as a consequence of) ш resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ 1 Live Birth 2 Live Borth 4 Pregnant at time of death for in the past 12 months?
1 ☐ Yes 2 ☐ No Month detached the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy performed? Yes 2 N After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) မ 1 🗌 Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work' death. 2 Accident 1 Yes 2 No Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D22574 NOVEMBER 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 OLD LINE CENTER, SUITE 302 R. TIMOTHY PACE, M.D. 20604 WALDORF, MARYLAND

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed

acked

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per MF g910 12/6/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 1, 8:55P JAMES RUDDELL COBEY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES CRESCENT CITIES CENTER RIVERDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. DECEMBER 29, 1958 MARYLAND 218-76-5186 51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√∏Yes 2□No ms 23a or 28a-f sh Director NEWBURG MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9809 SYLVAN TURN 20664 UNITED STATES Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after Never Married 2 Married Maryland 21215-0036 9 1 □Yes 2 X No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE LANDSCAPER LANDSCAPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be EUGENE ALLEN COBEY Ith and Ment 27 is marked traumatic e ALEAN JILES COBEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 9809 SYLVAN TURN, NEWBURG, MARYLAND BONNIE E. CARROLL / SISTER Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or once. 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAK GROVE CHURCH CEMETERY NOVEMBER 8,2010 NANJEMOY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Standure of Funeral Service Libernaee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 25 ALYLIA C. THORNION JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician enegnal In farction 244 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner teriosclerotic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-transi be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Diabetts Unelliter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate vadrantepic Spas 1 ☐ Yes 2 ☐ No 2 🗆 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1XYes 2210 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. spital or Attendi nours after death. neral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier e and address of person who completed cause of death (Item 23a) (Type, Print) Overesum Rd Hyattsoille MDOSI 31. Date filed 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 7110 Mary Cunningham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days 1 □ M 2 🕱 F Months Director 579-46-7172 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20002 United States 1903 Capitol Avenue NE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk Bessie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Reid - Daughter 428 Short Hills Drive Charlotte, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 8 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony 2010 Stewart Funeral Home, Signature of Funeral Service Licenses 22. Name and Address of Facility Inc. 20019 4001 Benning Road NE Washington, DC 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 02 Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregnation 5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes this certificate has 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Schipatient 2 ☐ ER/Outpatient 3 ☐ DOA e Hospital or Attending Ph 24 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

P.O. Box 68760

DHMH 17 Rev 7/2009

Registrar

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Louise Centra 1:05 November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3118 Madison Street Prince George's Hyattsville 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 214-16-7954 89 **Director** Bladensburg, MD February Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f sl notified Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? must be r Funeral 3118 Madison Street 20782 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 2 🔀 No ☐ Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) I Hygiene. other than College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked or traumatic even ည James Henry Owens Mary Azel Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 James Michael Centra / Son 590 Marley Run, Huntingtown, MD 20639 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other Page 1 cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 11/6/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir Hypertension sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Atherosclertic Heart Disease Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖾 No signed by the atte Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗆 Yes 2 🗷 No 3 🗆 Probably 4 🗀 Unknown cate has been sig page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 🗌 Yes 2 🗀 No 2 X N Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 32. Registra

M.D

Kempanna Sudhakar, 7610 Carroll Avenue, Suite 230, Takoma Park, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

11/3/2010

29c. License number

D19971

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check

29b. Signature and title of certifier

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5 2010

10-08376 Devonte Marquis	Cli	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		ible.	36238					
Physicia	1	i- For State Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death					
Medical Examir	ner	DEVONTE MARQUIS CLINTON	Month November		0901 hrs					
		4a. Facility Name (if not institution, give street and number) Fort Washington Hospital Center 4b. City, Town, or Location of Death Fort Washington	h	4c. County of Death Prince George						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 579 25 7820 1 M 2 F 15 Yrs.	_		thplace (State or arWASH . DC ountry)					
land f show any once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location FT. WASHINGTON		g. Citizen of What Cou	10d. Inside City Limits 1 X Yes 2 No					
the Mary	Director	10e. Street and Number 10f. Zip Code 9202 LORELEI COURT 20744	10	USA	nu y :					
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland men to Fleath and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 \(\begin{align*} \text{Never Married} \ 2 \end{align*} \text{Married} \\ 1 \(\begin{align*} \text{Never Married} \) 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\begin{align*} \text{Yes} & 2 \end{align*} \) 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerton Contains) of the property of th		14. Race - Amer White, etc. Specify: BLA	ican Indian, Black,					
hours af "natural	ted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Constant in a completed in a complete in		16b. Kind of Business/	Industry					
036 rithin 72 rne. r than	Completed	11 STUDENT		SCHOOL	<u>. </u>					
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	JOHN GORDON ANIT		TON						
MD 21 nd 2 should alth and Me in 27 is ma	유		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z ANITA GORDON / MOTHER 9202 LORELEI CT. FT. WASHINGTON MI							
Baltimore, MD permit. Pages 1 and 2 sht Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) I T N COT N MEM CEM 1 1	Date	20c. Location - City or SUITLAND	Town, State					
Baltimore, permit. Pages 1 ar Department of Hes Important: I itelinjury or other tr		4 Donation 5 Other Specify: 21. Sinn ture of Funeral Service Licensee 22. Name and Address of Facility WATSON F H 3435		20	VASH. DC					
Physician	\dashv	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.			Approximate Interval Between Onset and					
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease or condition resulting in death) Due to (or as a consequence of):	ease		Death					
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
cecuted 1 and - transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.								
D, be exec sician a	edical	X UNPENDED AMENDED 23a,27,per ME g910 12/27/10 TT	_							
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial		23b. Was decedent pregnant in the past 12 months? Texact: 23c. If yes, outcome of pregnancy 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	nancy	23d. Date of deliver Month	y Day Year					
P.O. Be es that the dealing be detached for	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	_					
Division of Vital Records, P.O. Box tast or Attending Physician: The law requires that the death ras after death. **I Director: After this certificate has been signed by the atterior by the funeral director, page 2 should be detached for a	Completed		24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of					
Vital Roysician: The	Be Co	25. Was case referred to medical examiner?	(only one)							
of Vid	P	1 Yes 2 No lossifier 1 Inpatient 2 ER/Outpatient 3 DOA Norsi 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Othe	r:					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Certification:	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (S	treet and Number or R	ural Route Number, City					
E 8 E		Suicide Could not be determined (Specify)	or Town, Si	tate)						
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	e(s) and manner as sta and place, and due to the	ne cause(s)					
	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo November 3, 20						
20		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201							
St Regist		31. Date filed (Month, Day, Year) NOV 1 2 2010 32. Registrar's Signature								
DHMH 17 Rev 1/2		ORIGINAL	COME		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 3:15 P M 10 2010 Charles M. Cook Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4007 Old Columbia Pike Ellicott City Howard If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 A M 2 □ F '. Age (In yrs. last birthday) **Funeral** Days Months **Director** 80 202-22-3646 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County must be notified at Directo 1 Yes 2 No MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 0 er than "natural", or items 23a the Medical Examiner must by Funeral United States 21043 4007 Old Columbia Pike hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes Give Completed 3 Widowed 4 Divorced Year or Dates. 1946-55 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager of Facilities Service 2 WR Grace injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) uld be file Mental H Matt Cook Bessie Cogswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trans 4007 Old Columbia Pike Ellicott City, MD 21043 JoAnn Cook - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 11/3/10 Marriottsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licensee all M01044 4112 Old Columbia Pike Ellicott City, MD 21043 wo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury OBSTRUCTION BLADDER DUTLET To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth
4 ☐ Pregnant a
g ☐ Unknown in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown Division of Vital Records, been si should I Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 81 RIDGE RD, COLUMBIA, MD 21044 10801 IKECHUKWU MBONG HICKORY 31. Date filed (Month, 32. Registrar's Signature State 2010

Registrar

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Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
Amend 24a per med cert G910 12,6/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1825 JULIE GIBBONS-NEFF COX october 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TAIDOT Memorial HOSPItal EASTON If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Days Hours Min. Country) 59 04715/1951 Director Yrs. 184-42-2488 PA Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7462 WAVERLY ISLAND ROAD 21601 UNITED STATES 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) NON-PROFIT the ADMINISTRATION ORGANIZATION or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ GRELLET GIBBONS-NEFF PHYLLIS BARBA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau DAVID M. COX / HUSBAND 7462 WAVERLY ISLAND ROAD, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CENTER

Cemetery, crematory or other place)

CENTER 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) 10/28/2010 STEVENSVILLE, MD 21. Signature of Fundral Service Licens) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601 the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Interval Between Metastatic lung Onset and Death Immediate Cause (Final Carunama Physician/ disease or condition Medical resulting in death) Examiner Pneumonia Obstructive Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnan 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 🔲 No 3 Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ha

To the Fune
completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) Moham MD 00069567 Uct, 26, 2010 725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 RAVI MOHAN, MD 219 S. WASHINGTON STREET, EASTON, MD 21601 31. Date filed (Month, Day, Year) State OCT 28 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 2010 8:25 РМ MILDRED MAE CORNELIUS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Filcare Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** March 12, Year) 1919 Months Days Hours Min 1 🗆 M 2 😾 F Maryland 91 217-32-5080 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by once. by Funeral U.S.A. 21740 1930 Applewood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 🕅 Widowed 4 🗆 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Optical Lens Assembly Line 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nora Annie Whitehair Clarence Mullendore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald W. Cornelius / Son 55 Spooner Court, Harpers Ferry, WV 25425 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 11/2/2010 Smithsburg, Maryland Sign to of its ROBERT E. DAILEY & SON FUNERAL HOMES, P.A NORTH MARKET STREET, FREDERICK, 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause or each he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Alzheimer's demontia 10 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician a Physician/Medical Box 68760 as attending | IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L reia acc Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) ed by the a ☐ Unknowr 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 \square No Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specific Notes)} \) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ٥ 11/01/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1138 21740 Tu BuiMD - Opel Cf. 31. Date filed (Month, Day 32. Regist ar's Signature State NOV Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia		Roy Delbert Cro	*							Octobe		Day 5 •	201 ^{Year}	- 1	12:45 AM
Medic Examin		4a. Facility Name (if not institution,	give street and num	ber)		4b. City,	own, or l	Location of	Death		$\overline{}$		unty of Dea	_	
Francis	ų	Western Marylar 5. Social Security Number		7. Age (In yrs.		If Under	`	gersto		8. Date of Bi	rth	W	ashin		n e (State or Foreign
Funeral Director		235-60-8687 Usual Residence of Decedent	1 ⅓ M 2 ☐ F	70 70		Months	Days		Min.	Aug. 2		940	0 We	ou <i>ntry)</i> S t V	irginia
rryland a-f show ied at	Director	10a. State 10b. County	i-ata-	10c. Ci	ty, Town or Loca										Inside City Limits
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ld be file Mental H arked of atic evel	To B	17. Father's Name (First, Middle, La John Crookshank						18. Mother Lena		e (First, Middle ∛e	, Maide	en Surr	name)		
shou thand 7 is m traum		19a. Informant's Name/Relationsh Connie Crooksha								A Route Numb					
f Healt f Healt item 2 other		20a. Method of Disposition	ilik / Wile	20b. I	Place of Disposi	tion (Nam	e of			Boon	_		ion - City o		
tment or tant: If jury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State M	Resthay lemorial	tory or ot en Gar	he <i>r pl</i> ace, dens			ber 29, 010					cyland
Departing Departing Important and in conce.		21. Signature of Funeral Service Li	censee		Re:	Name and Sthav	Address en I	of Facility Funera	al S	Service	s, 8	Skk	ot Co	dy I	P.A. MD 21701
		23a. Part 1. Enter the disease, or a shock, or heart failurg. List or	complications that call	aused the deat									uci ic	Арг	proximate erval Between
hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)			ratory :	Failu	ıre								set and Death
Examiner	,			or as a conseq .c Obst	ructive	Lung	g Dis	sease		0.	1	1		20	days
sit a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		or as a conseq	uence of):			,	. 11		M,	M			
an and ial-trar	_	that initiated events resulting in death) Last	c. Due to (c	or as a conseq	uence of):			19	CATION THE	ON APPROVED	BY MED	ICALE	XAMINER		
physicia the bur	edica		d					CEKN	IFICAL						
ending ruse as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregna		Ectopic p	egnancv	,				23d	. Date of de	elivery	
y the at	hysici	1 Yes 2 No 9 Unknown	4 ☐ Pregr g ☐ Unkn	nant at time of own	death 5 🗌	Other (spe	ecify)						Month	Day	Year
gned b	þ	Part II. Other significant condition			3	, ,	3								use of death?
equire seen si hould l	eted	Ventilator Depe						2							/ 4 ☐ Unknown
ate has b	Completed	Traumatic bra	irii injury	WICH	Сощртте	actor	19			24a. Was auto perfe 1 \square Yes	psy ormed?	.	prior to death?	comple	indings available tion of cause of
ertifica ector, p		25. Was case referred to medical examiner?	Hospital:					ce of Death	(Check			110	, ,,,		
this c	임	1 X Yes 2 X No 27. Manner of Death	1 K I		ER/Outpatient 28b. Time of		Other.	_4 L Nurs		me 5 Resi				cify)	
or: After	ficate	1-X Natural 5 Pending 2 Accident Investig	ation 09/27	h, <i>D</i> ay, Year) 11997	injury Unknow		work?		- 1	Subjec				1ado	der
	28a. Date of injury occurred 28d. Describe how inj								ast P	iral Roui atr	te Number, ick St.,				
24 hour 25 hour Funera eted fille	Medical	(Check 2 L Medical Ex	Physician: To the becaminer: On the basi	s of examinatio	n and/or investig	ation, in m	y opinion	, death occu	ace, and	d due to the ca	ause(s) a	and m	anner as st	cause(s)) and manner stated.
within To the compl		20h Signature and title of certified	Nurse Practioner: T		y knowledge, dea		License r		na piao	e, and due to tr			gned (Mont		Year)
		+ frastr	Irade			D	2789	98			Octo	obe:	r 25,	201	10
5		30. Name and address of person w Francisco L. An					ınia	Ave.,	. На	gersto	wn,	MD	2174	2	
State	е	31. Date filed (Month, Day, Year)			ture .										
Registra		001 4	FOR GO V	Mary Carlon Carlon	- 10. 17	-									

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 26, P^{M} 2010 Ok Ryun Cho 7:30 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6 Sex 7. Age (In vrs. last birthday) **Funeral** July 20, Korea Days 1 □ M 2 🎛 F 215-31-9033 1926 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland| Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18504 Cross View Road 20841 Korea 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Peoung Kook An Soon Lae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chae Cho / Son 524 E. Franklin Street, Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of competer, crematory or other place)
Restnaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State October Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fundal Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Shock Septic h sician/ disease or condition resulting in death) Medical Due to (as a consequence of) Examiner urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Compane at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by unknown origin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? lymph adenopathy 24a. Was an After this certificate has page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) æ Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) OCTOBER, 27th, 2010 Kane' MD D068178 20 aue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Pockrilly Maryland 20850 Rane, MD 20 032. Registrar's Signature 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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BOTOB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Drake Jr. Joseph Presley 2010 Medical October 6 1 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Days Min. 579-20-5789 Months Hours 0473071925 Alabama Yrs **Director** 85 Usual Residence of Decedent fshow 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Florida Indian River Vero Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 32962 226 23rd Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married X Yes 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates. Navy white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) engineer technician US Naval Academy Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Presley Drake Sr. Wilhelmina Saul 19a. Informant's Name/Relationship (Type, Print)
Joyce Swann/daughter 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town State Zip Code)
118 Stratford Place, Dobson, NC 27017 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Springhinal Methor 190 1 K Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 11/2/2010 Gardens Hebron, MD RNATE WAS ASSOCIATION FOR STORY ASSOCIATION SOLVEN TO THE PROPERTY OF THE PROP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death utricula Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed' Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

P.O. Box 68760

Joseph

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions.

State Registrar

1 🗌 Yes Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗶 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signaturg and title of certifier 29d. Date signed (Month, Day, Year) R 135131 October 28, 2010

28c. Injury at

2 🗆 No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

nd address of person who completed cause of death (Item 23a) (Type, Print)

CRNP Pennie Savage, 9715 Healthway Dr, Berlin, MD 21811

31. Date filed (Month, Day

5 Pending

1 ☐ Yes 2 XNo

27. Manner of Death

X Natural

egistrar's Signature

1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death NOVEMBER 2 2010 1:45 A M .TEAN DUDLEY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ASPENWOOD SENIOR ASSISTANT LIVING SILVER SPRING 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Days Min 1 □ M 2 🕮 MAY 124 VIRGINIA 1932 231-34-8294 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ☐ No PRINCE GEORGE'S SPRINGDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3609 JEFF ROAD 20774 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes BLACK 1 ☐ Yes 2 K No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 4YRS Elementary/Seconday (0-12) ASTRONOMER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BINFORD GLADYS MANNING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY NASH/ATTORNEY ROCKVILLE PIKE #400 ROCKVILLE, MARYLAMD 20852 1700 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/9/2010 HARMONY LANDOVER MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNÉRAL HOME 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Onset and Death uence of)

Physician/ Medical **Examiner**

Examiner

Physician/Medical

Be Completed by

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Certificate:

Medical

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 shown injury or other traumatic event, the Medical Examiner must be notified at anne.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	a. –	Due to (or as a consequence of):
	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying	J b. –	Due to (or as a consequence of):
	Cause (Disease or iinjury that initiated events resulting in death) Last	c	Due to (or as a consequence of):
		d	
ì	IF FEMALE:		

d
23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown

th	3 Ectopic pregnancy 5 Other (specify)	
tn	5 Other (specify)	_

23d. Date of delivery

Month Year Day 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabotes Mellitus Stage

1 ☐ Yes 2 🛭	No 3□Pro	bably 4 🗆 l	Jnknown
24a. Was an autopsy performed? 1 Yes 2 No	death?	opsy findings a ompletion of ca	vailable ause of

o medical o
Pending Investiga Could no

31. Date filed (Month, Day,

NOV 0 5 2010

23b. Was decedent pregnant in the past 12 months?

9 Unknown

2 480

1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) nvestigation 6 Could not be

Hospital

1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □	DOA	4	□ Nursing
28a. Date of injury (Month, Day, Year)	28b. Time of injury			Injury at work?	
		M		1 \sum Yes	2 🗌 No
28e. Place of Injury - At he building, etc. (Specif)		t, facto	ry, of	fice	

26. Place of Death (Check only one)					
Other: 4 \(\sum \) Nursing H	ome 5 Residence 6 Other (Specify)	ASSISLE			
	28d. Describe how injury occurred	livin			

28f. Location (Street and Number or Rural Route Number

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Che only

(Chec	ck	2 Medical Examiner: On the basis of examination and	d/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
only o	one)	3 Certifying Nurse Practioner: To the best of my known	wledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signa	ture an	d title of certifier	N .	29c. License number	29d. Date signed (Month, Day, Year)

olame, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	20d. Bate signed (Workin, Bay, rear)				
063999	11-3-2010				

determined

ATA MUSTAMEDI M.D. 17904 GEORGIA AVENUE #304 ONLEY, MARYLAND 20832

State Registrar 32. Registrar'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Harry A. R. C. Draper 2010 10:45 AM October 31 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Abundant Love Homes Assisted Living 11214 Snowden Pond Road Prince George's Laure. If Under 1 Year . Age (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min (Month, Day, Year) 2/20/1921 13/23/M 2 - F 88 **Director** 188-12-6515 Easton, Pa Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No MdPrince George's Capitol Heights 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? with 1 23a Funeral 6319 Carrington Court 20743 U.S.A. items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married "natural", or Maryland 21215-0036 African-If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ₩ Widowed 4 Divorced American event, the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Office Service Manager-NAVSUP years U.S. Government Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew ည George W. Draper Grace Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Motiryo C.D.N.Keambiroiro/Daughter # 13 Beaver Creek Ln., Durham, N.C. 27703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat'l. Mem. Park 11/06/10 Laurel Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. any and a4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) COPD Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or ilinjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 4 ☐ Pregnam
g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1

Yes 2

No 3

Probably 4

Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy certificate has director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗖 No Assisted Other: 4 Nursing Home 5 Residence 6 Other (Spec Hospital: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Living After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 7/2009

9200 Basil Court, # 200, Largo, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

Ivan Zama, M.D.

31. Date filed (Month, Day, Year)

NOV 0 5 2010

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20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 29° 201^{rea} 4:30 A M Esther Η. Deel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Briar Meadows Assisted Living Montgomery Derwood Date on (Month, Day, 28, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. South Carolina Yrs Director 579-03-8292 1910 100 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Derwood Montgomery 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 17505 Park Mill Drive 20855 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: "natural", Completed 3 X Widowed 4 □ Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Federal Government Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Jim Fender Mikellah Mahala Folk Hiers traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Page 1 and 2 sh ment of Health a Catherine Hill Sutton/ Important: If item 27 17505 Park Mill Drive Derwood, Maryland 20855 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Final Journey Crematory 11/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 any M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Pardi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 24 hours Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) physician and the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Year Pregnant at time of death g Unknown Unknown s been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law i within 24 hours after death. To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy 2 🗆 No 1 Tes 2 X No Yes **Division of Vital** Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Assisted-1 ☐ Yes 2 ₺ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Suicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760

P.O.

State Registrar (Check

31. Date filed (Month

29b. Signature and title of certif

Barry N. Rosenbaum,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Creun

DHMH 17 Rev 7/2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D09834

3720 Farragut Avenue Kensington, Maryland 20895

29d. Date signed (Month, Day, Year)

October 29, 2010

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** GRACE DUDLEY 5:05p 26 2010 /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Talbot Genesis Health Care-The Pines Easton . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2**K** F 76 07/23/1934 MD Director 214-32-6456 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, he Medical Examinar must be nettlised at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director TALBOT **EASTON** 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code UNITED STATES 21601 610 DUTCHMANS LANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X** No Sarah Dudley Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **NEWSPAPER** PAPER CARRIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARLTON WALLS LENA ESTHER STACK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 6215 N. HALE AVE., TAMPA, FL 33614-4802 LINDA S. WRIGHT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER
Date
10/29/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee 101/12-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** one year /Medical Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) this certificate has been signed by the al director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Dutchmans Ln Easton MD 21601 Michael ا ف MD 31. Date filed (Month, Day, Year) State **OCT 29** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:45 A M 2010 Betty Veit Dean October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 322 Northwest Drive Silver Spring . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 9, 1931 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Davs Hours California Director 577-40-2968 79 Usual Residence of Decedent or 28a-f shov lid be filed within 72 hours after death with the Maryland Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 322 Northwest Drive 20901 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Ohental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fritz Gleim Jackson Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a Stephen A. Dean/husband Silver Spring, Maryland 20901 322 Northwest Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/2/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 12 Thomas M00957 uanita MD21029 23a. Pan). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 13 months shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic Breast Cancer to Lung, Liver, Bone disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Prior Stage II Breast Cancer 3vears Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a detached f 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate I 1 Yes 2 No 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) 2X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? **X**Natural injury 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of centiler 29d, Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

gistrar's Signature

32. R

Hendricks,

Carolyn B.

Date filed (Month)

D37236

6410 Rockledge Drive, Suite 506 Bethesda, Maryland 20817

October 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 7:00 P M October Paul Hoye Enlow Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Garrett Goodwill Mennonite Home Grantsville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth June 13 1 X M 2 D F ^{ea/}1927 Illinois 359-20-7425 83 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Accident Garrett 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21520 USA 1267 Aiken Miller Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White WW2 Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor U.S. Tobacco Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Louise Hoye Lyman Sedwick Enlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Box 64, Accident, MD 21520 Helen L. Enlow/Sister P.O. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope Cemetery Nov. 6, 2010 Champaign, IL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. umale P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused shock, or near failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death MYOCARDIAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last executed and tran Due to (or as a consequence of) attending physician of for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗀 No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 TResidence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 2 🗌 No Accident
Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

d

State

Robin Bissell, 31. Date filed (Month, Day, Year)

NOV -1

21536

124 Miller St., Grantsville, MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible disk Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2010-36251 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3°Y Oct 2010 Esther R. Fisher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Deer's Head Hospital Center Social Security Number If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. July 10 Year) 1928 Director 82 213-22-9644 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Wicomico Salisbury MD10e. Street and Number 10f. Zip Code 21801 Funeral 632 Suffolk Court USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory/Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ၉ Anniebell Martin Ward Ben Davis any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Betty Purdue/daughter Suffolk Court, Salisbury MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cem 11/6/2010 Berlin, MD Signature of Funeral Service Licensee TD Watson per DVR 618 West Road, Salisbury MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Advanced Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cerebral Vascular Accidents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown signed by the atte Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, Completed 24a. Was an autopsy performed? Yes 2 No page death? 25. Was case referred to medical Division of Vital

3. Time of Death 08:50 AM Wicomico g. Birthplace (State or Foreign Country) MD 10d, Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black AWhite ietcan-Specify: American 16b, Kind of Business Industry Poultry/Private School 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22. Name and Address of Facility Lewis N. Watson Funeral Home Approximate Interval Between Onset and Death year plus More than 1 year ago Hospital or Attending Physician: The law requires that the death certificate be executed 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 1 Yes 2 No after death.

Director: After this certific Be 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1

Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d, Date signed (Month, Day, Year) D0002038 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buchness, MD Deer's Head Hospital Center, Salisbury MD 21802-2018 32 Registrar's Signature 31. Date filed (Month Day Yea) 2010 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 316 P MARGARET 0. **FADERO** 25/0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTORS COMMUNITY HOSPITAL LANHAM 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 M 2 K Month, Day, Year, Washington, DC 577-17-5234 32 1978 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD PRINCE GEORGE'S BOWIE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 11107 HUDEE COURT USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 🖾 Never Married 2 🗌 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) 2 YEARS Elementary/Seconday (0-12) PRIVATE STUDENT Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည VERONICA I. ADOADO LAWRENCE M. FADERO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE FADERO - BROTHER 1718 T. STREET, S.E., WASHINGTON, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/2010 BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify) FORT LINCOLN CEMETERY 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature of Funeral Service License 716 KENNEDY STREET, NW, WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Savur Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner cut 6 Sequentially list conditions Examine sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): >60 00 C Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nhknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural iniury 5 Pending death. To the Hospital or Attendia within 24 hours are desth. To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1267 40

State Registrar

Margare

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8/18 Good huckled., Lacham, MD. 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abrodu

31. Date filed (Month, Day, Year)

NOV 0 4 2010

Please Type or Print in Black Indelible Loke Firsty Place Opies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 5, **Physician** 2010 3:25 P M Nov. Michael Eugene Frickey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town or Location of Death Examiner Garrett Grantsville 12376 National Pike If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Funeral 5. Social Security Number Months 1 ▼ M 2 □ F Director 60 4/24/1950 Maryland 217-54-7083 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County in than "natural", or items 23a or 28a-f show 1 ☐ Yes 2√ No Completed by Funeral Director Grantsville MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21536 U.S.A. 12376 National Pike 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify:White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Manufacturing Painter other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frickev Wilbert McKenzie Mildred Mae ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12376 National Pike, Grantsville, MD 21536 Jane L. McCracken/ Friend 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Countryside Crematory 11/6/10 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complication that cused the shock, or heart failure. List only one conse on each line. that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL /Medical Due to (or as a consequence of): Examiner Unsule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Month Year 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 ☐ Yes 2 XXIII Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11/5/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year) Registrar

NOV

Robin Bissell

32. Registrar' Signature

124 Miller St., Grantsville, MD 21536

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feger Physician/ Barbara 10 31 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Howar Hospita. Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 1 F (Month, Day, Year 6/2/1947 218-48-2651 63 Yrs. Director MD Usual Residence of Decedent ms 23a or 28a-f shov must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8525 Marybeth Way 21043 United States iral", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry James Gray Dorothy Welmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD 21043 Ed Feger Sr. - Husband 8525 Marybeth Way item 2 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location City or Town, State Date Department of F Important: If ite any injury or oth cemetery, crematory or other place) Meadowridge 4 Donation 5 Other (Specify) 11/4/10 Elkridge, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Li M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diabetes Ph_sician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions Examiner if a y, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit or Attending Physician; he law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by renal Failure 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, autopsy Depression after death.

Director: After this certificate Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pkny #301, columbia, MD 21045 Snowden 10 River Harry 8600 31. Date filed (Month 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

				Partificate of Death	Reg. No.
	Dhysisi	ž.,	Decedent's Name (First, Middle, Last)	2. Date of I Month	Day Year
	Physici /Medic	_	Rachel T. Fitzgerald		er 27, 2010 1:48 p ^M
7	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Montgomery
	- ×		Friends Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Sandy Spring ay) If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. (Month, I	0 -
	Funeral Director		219–16–0680 ¹□M 2⋈F 86 Yrs	Months Days Hours Min. (Month, I	10 1924 Maryland
	and and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location	10d. Inside City Limits
	Manyi f sho	tor	Md. Howard Colum	b i a	1 □Yes 2 X No
	ith with the Marylar 23a or 28a-f show	Olrec	10e. Street and Number	10f. Zip Code 21046	10g. Citizen of What Country? United States
	s 23a	rall	7450 Setting Sun Way		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Modical Examinational and once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	Black, White, etc. Specify: White
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of working le. DO NOT use retired)	16b. Kind of Business/Industry
121	within ane. then "	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) Travel Agent	Tourism
2	filed withi Hygiene. other than ent, ILE M	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
an	Mental Merked o	To B	Clinton Thomas Trott	Elsie Whitt	ington
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Manatic event ev	-		ailing Address (Street and Number or Rural Route Num	
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 20b. Place of Dispersion 1 □ Removal from State	sposition (Name of Date crematory or other place)	20c. Location - City or Town, State
ţ	permit. Page Department of Important: If any injury of once.			olitan Crem. 10/28/10	Alexandria, Va.
Bal	permi Depar Impo any ir		21. Sign larg of Funeral Service License e	Muriel H. Barber Funera P. 0. Box 5038, Layton	al Home nsville, Md. 20882
100	-		23a. Pyri1. Enter the disease, or complications that caused the death. Do not slock, or heart failure. List only one cause on each line.		
	Physician		Immortate Cause /Final	in fanction	Interval Between Onset and Death IM HEDITTEL
	/Medical		disease or condition resulting in death) a. Myocarbia Due toylor as a consequence of)		THE OWNER
	Examiner		Sequentially list conditions b.		
	be is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
	and and I-trans	хаш	that initiated events resulting in death) Last Due to (or as a consequence of):		
68760,	tificate be executed ig physician and as the burial-transit	alE			
687	ificate g phy: as the	ledical	Q.		
Box		an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy	23d. Date of delivery
-	The law requires that the death cer te has been signed by the attendir age 2 should be detached for use	Physiclan/N	1 Yes 2 No	5 Other (specify)	Month Day Year
P.0	hat the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	ue underlying cause given in Part 23e. Di	id tobacco use contribute to the cause of death?
ds,	signe d be c	d by	Decp Vei: thrombsphlebiris		☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Records,	w requir been s should	lete	Dementia	24a. W	as an 24b. Were autopsy findings available
Re	The lavate has	Completed	- CHOCK M	pe	prior to completion of cause of death? s 2 ☑ No 1 ☐ Yes 2 ☑ No
Vital		a	25. Was case relerred to medical	26. Place of Death (Check on	-
>	S S	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		esidence 6 Other (Specify)
n of			27. Manper of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju	ry Work?	be how injury occurred
Si	Attending r death. sctor: After	cat	2 Accident investigation	M 1 Yes 2 No	n (Street and Number or Rural Route Number,
Division	after of Direct In by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		Town, State)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the desired physician of examination and of and manner stated.		
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
) M 10	1218158	October 28,2010
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type 1.5 and 1	(pe, Print) P. 1. Ph. 1. A. 7-12	OLNIEG MA 7.86,
	Le St	10	31. Date filed (Month, Day, Year) 32. Registor's Signature	in water wash or	-107.10016
2	Sta Regist	ar	OCT 29 2010 Denun &	. bare	
	10.15			-1/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Gulick October 26, 2010 Physician/ Joseph 6:00 A Leonard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cheverly Prince George's General Hospital 7. Age (In yrs. last birthday) 8. Date of Birth Dec. 3, g, Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 1 XXM 2 - F Months Pennsylvania 7952 175-44-7492 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State **Funeral Director** 1 Yes 2 XNo Germantown Maryland | Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number **IISA** 20874 12125 Flag Harbor Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status Was Decedent E.S. Armed Forces? 1 ••• Yes 2 \(\text{No.} \) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ð XX Never Married 2 Married 1 XYes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2x No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Courier Driver years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Elizabeth Rohalv John Gulick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29585 115 Windover Drive Pawleys Island, S.C. Elaine Schroder / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 Cremation 3 Removal from State 11/15/2010 Cheltenham, Maryland Maryland Vet. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Lice 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Mellin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown tor: After this certificate has been signed by a the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 K 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No 1 Npatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of ceath (Item 23a) (Type, Print) 30. Name and address of pers AIM 31. Date filed (Month, Day, State NOV 0 4 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 2053 M Mervin 5010 oʻ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of D∉ath **Examiner** 10359 Green Mont ٤ 23262 Ver Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 **X**M 2 □ F Min (Month, Day, New Jersey Director 78 May 265-40-4525 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 United States 10359 Green Holly Terrace Iral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 🙀 Divorced Year or Dates. 1952-54 event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Automobile Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) ပ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Herman Glick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Glick/son 608 Ednor Road Silver Spring, Maryland 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/1/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, M uanta Romas MD 21029 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or impury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 🗌 No been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsv performed? Yes 2 No death? 2 🗆 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Hospital Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifie **Check** within 2 To the F ally one) ature and title of certific ひつつりょり MOOME NKASSUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD Oma gistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Milante 7:40 M Physician/ 2010 Geissinger Lee Nancy Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5, Social Security Number **Funeral** Jan. 17, Year 1932 Months Days Hours Min. Maryland 1 □ M 2 🗓 F 78 **Director** 217-28-7143 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🕅 Yes 2 □ No Hagerstown MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21742 470 Pangborn Blvd. filed within 72 hours after death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. 3 🔀 Widowed 4 🗆 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 is and Menta! Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rena Miller other traumatic George Weagly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 237 Pangborn Blvd., Hagerstown, MD . Page 1 and 2 st tment of Health a tant: If item 27 i Susan K. Witmer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a De artment of h Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 11/15/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Examiner So controlly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 use as signed by the attending be detached for use as yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗎 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Yes I Notine 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatie 2 XNo 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this of in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined within 24 hours af
To the Funeral Di
completed filled ir Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier Off son who completed cause of death (Item 23a) (Type, Print)

OC

Year

DHMH 17 Rev 7/2009 DIL

State Registrar 31. Date filed (Month, Day, Year)

's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Hooper Shirlev Μ. 30, 2010 8:30 p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 M 2X F Feb. 26, 1930 Washington, D.C. 578-34-9279 80 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Frederick Mt. Airy Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral within 72 hours after death with 21771 USA 306 Westridge Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: white If Yes, Give Specify: Completed 3 Widowed 4 X Divorced Year or Dates and Mental Hygiene.
is marked other than "naturraumatic event, the Medical!" 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Giant Foods Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ည Irene Garlick Robert Parkhurst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Westridge Drive, Mt. Airy, Maryland 21771 19a. Informant's Name/Relationship (Type, Print) Bonnie Deblois - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) 11/2/2010 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21704 23a. Part 1. Enter the disease or complications that caushock, or heart failure. List only one cause on each or complications that caused We death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 86structive Munanay Onset and Death Immediate Cause (Final Physician/ MONTH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a sunsequence on: Exami and I-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician a be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician; The law cate has autopsy performed 1 🗌 Yes 2 🗌 No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 🔀 Natural work' 2 🗀 No 1 🗆 Yes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signat re an e of certifier 29d. Date signed (Month, Day, Year) 20062223 November 2, 2010

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Da

DELVE, FLEDERICE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regissar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State of Maryland Department of Floath and Method Registrar #11,17,19a,perF.H.,11/5/10 Certificate of Death BA WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 Carol Kelly Hamilton October 3:50 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Months Days Hours Min. 75 215-34-0848 /23/1935 N.IUsual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 ¥ Yes 2 □ No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 William Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify.White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teaching Aide Education 17. Father's Name (First, Middle, Last). Henry Russell Kelly 18. Mother's Name (First, Middle, Maiden Surname) Henery Russell <u>Anna Mae Craig</u> 19a. Informant's Name/Relationship *(Type, Print)* Marshall Hamilton Marshal Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William St Berlin MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cape Hen. Crematory Frankford DE 11/2/2010 22. Name and Address of Facility 108 William St. Berlin MD <u>Burbage Funeral Home</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician/ Medical **Examiner**

Amended item

Physician/

Medical

Director

Funeral

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Immediate Cause (Final

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennie Savage, CRNP 9715 Healthway Dr, Berlin,

Registrar's Signature

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

IAMILTON, CAROL Baltimore, Maryland 21215-0036

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the Hospital or Attending Physician: The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760

Examiner by Physician/Medical Be Completed Medical Certificate: To

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that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
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25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	
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27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
(Check 2 Medical Examine	ian: To the best of my knowledge, death occured at the time, date and place, and size of the basis of examination and/or investigation, in my opinion, death occurred a Practioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place	ce, and due to the cause(s) and manner stated.

29c. License number

R 135131

29d. Date signed (Month, Day, Year)

21811

November 1, 2010

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State

Registrar

backer

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medica Examine		4a. Facility Name (if not				HOW	4b. City, Town, o	or Location of Dea		4c. Cour	ity of Death	110
Funeval		Souther 5. Social Security Number		7.A	ge (In yrs. la:	st hirthday)	If Under 1 Year	or I If Under 24 Hrs	8. Date of Bir	Priza	9. Births	State or Foreign
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Medical Examiner		disease or condition resulting in death)	C a	Due to (of a	s a conseque	ence of):	Piver	MON	va_			
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 v.	ate: To	27. Manner of Death 1 Natural 5	☐ Pending	28a. Date of in (Month, D	jury	28b. Time of injury	28c. Inju wor	ry at k?	Home 5 Residence 1			2
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined	28e. Place of Ir	njury - At hor	me, farm, stre	M 1 L	Yes 2 No	28f. Location (S		nber or Rural	l Route Number,
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the Hos nin 24 h the Fun npleted	Medical	(Check 2 only one) 3	Medical Examine Certifying Nurse	r: On the basis of	examination	and/or invest	igation, in my opin	ion, death occurred	d at the time, date a	and place, and	due to the car	use(s) and manner stated
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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l#		M. TH	IMM	who completed cause of	death (Item	23a) (Type, P	erint)	TER	W 21+	OKE D	R,	SAUS	BU	RY MDZ1ROY
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 36263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0707 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Miamias SA43601 KEGIONAL If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex. 1 X M 2 □ F **Funeral** Months Days Min Director items 23a or 28a-f show 10a. State 10b. County City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Norlester 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 2/85 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🕅 No Specify. 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code)
1301 MARKE + ST. POROMOKE MD 2185 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 3 GREEN BOCKVILLE 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Home POBOX218 Tempopance ville VA 23442 Fox Funeral and . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line Non Small cell Lung Cancal Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) nding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the a should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy perform 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Aft eleted filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature nd title of certifier 11-2-2010 ddress of person who completed cause of death (Item 23a) (Type, Print) M.O. AUSTINIAN 100 E. CAIN. 32. Registrar's Signature 31. Date filed (Month

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER **DEBORAH** 2010 HOOD 12:35P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9014 RHODE ISLAND AVENUE PRINCE GEORGE'S COLLEGE PARK If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) JUNE 26 Days Hours 1 □ M 2 🖺 F °1955 VÍRGINIA Director 223-84-8049 55 Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. Director 1 Yes 2 No PRINCE GEORGE'S COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9014 RHODE ISLAND AVENUE # 802 20740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 XDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4yrs SALES MANAGER PRIVATE traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is marked oil any injuy or other traumatic even once. ပ္ UNKNOWN EVELYN B. HOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6337 LANDOVER ROAD CHEVERLY, MARYLAND 20785 TREMEKO HOOD/DGT 20a. Method of Disposition
1 ☐ Burial 2 【A Cremation 3 ☐ Rev 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) CREMATORY 11/5/2010 RIVERDALE, MARYLAND 21. Signatu - Uneral S Ace Licensee J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CARDIOPLUMONARY ARREST Medical resulting in death) Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner HYPERTENSION attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Line of death in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HEPATITIS C autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 X No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 1 X Yes 2 🗌 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/3/ D0067810 2010 ordals me

State Registrar SIDDIQUE 7582 ANNAPOLIS ROAD LANDOVER HILLS, MARYLAND 20784

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AMBREEN
31. Date filed (Month, Day, Year)

nov o

5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ela Eudora Holmes 2010 November 6:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months (Month, Day, Year, Country) Director 132-16-9291 84 0/08/1926 New York Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No Maryland | Prince George's Washington 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 6801 Bock Road #429 20744 , or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc δ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. and Mental Hygiene. 3 XWidowed 4 ☐ Divorced Specify: Completed Black Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Social Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johannis Christian Elama Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lanier (Daughter) 10313 Farrar Avenue, Cheltenham, MD 20623 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite 1 XBurial 2 Cremation 3 X Removal from State Calverton National 11/12/2010 injury 4 Donation 5 Other (Specify) Long Island, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, P.A. talliced 9013 Annapolis Road, Lanham MD 20706 a uma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Failure TUPOXIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner unoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Directo (or se a eunequende of, the burial-transit Rena that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician; The law requires Records, cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes 2 N funeral director, 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural 5 Pending n 24 hours after death. e Funeral Director: At bleted filled in by the fu 1 Yes 2 No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I complete only one) 29b. Signati and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 0 11/2/2010 D0068026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive, Olney MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year HEL BIG 652 A M EDWARD 25 10 DONALD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mencial Garratt (ounty 0 44010 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Year) Days Hours 1 M M 2 □ F Months 212-18-1526 Director 89 03 1920 MDUsual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Wedical Evander must be notified at Director 1 ☐ Yes 2 Mo MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3725 Underwood Road 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. ifiled within 72 hours after It Hygiene.
other than "natural", or ite 1 Mayes 2 No If Yes, Give1942-1945 Year or Dates 942-1945 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Jeweler <u>Own_Business</u> 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Edward Helbig Della F. Browning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Helbig-son 5677 Hutton Road, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. MemorialGardens Oakland, MD 22. Name and Address of FacilityDavid A. Burdock Funeral HOme P.A 21. Signature of Funeral Service License WAD 21 N. 2nd St, Oakland, MD 21550 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed te Cause (Final corona Vusuelar dise **Physician** 18001 disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 0 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 2. No 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending investigation Vithin 24 hours after usus.

To the Funeral Director: Af death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

ani 31. Date filed (Month, Day, Year)

30. Name and address of person who co

W.

NOV

32 Registrar's Signature

of death (Item 23a) (Type, Print)

69 Welf Azves Ocalcland MI) 21500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death October 29, 2010 Physician/ Isadore Honig 12:58 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 2 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8 Date of Birth Funeral Months Days 99 06/913 9949911 New Jersey 377-16-1832 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b County 10d. Inside City Limits 10a. State Director Maryland Montgomery Silver Spring 1 ¥ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20902 11505 Yates Street USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give ₩₩TT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ò 1 Never Married 2 Married Leattimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2 No Specify. Specify: White Completed WWII 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Legal Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Honig Esther November 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2421 East Madison Street, Seattle, WA Douglas Honig, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King David Meml Gdns 11/03/2010 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Af Fameral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852 MO1255 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Congestive Heart Failure years Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus Type 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dualto (or se a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decubitis Ulcer 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo ျ 1 Inpatient 2 ER/Outpatient 3 XDOA this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of မ 10 State Registrar

DHMH 17 Rev 7/2009

John

31. Date filed (Month, Day, Year)

NOV 02

nd address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

D36406

Merendino Jr, MD, 10215 Fernwood Road, Suite 405, Bethesda, Maryland 20817

29d. Date signed (Month, Day, Year)

November 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/28/2010 8:22 A M MARGARET DELORES HOLLAND Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🕮 Country) 08/14/1936 74 Director 215-38-2792 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 911 Dennis Avenue 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Yes 2 XNo 1 Never Married 2 X Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced th and Mental Hygiene.

77 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Domestic of Health and Mental Hygi of Health and Mental Hygi If item 27 is marked other ir other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Selby Thomas Gant 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Dennis Avenue, Silver Spring, MD 20901 Sterling Clifton Holland, Sr. Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of F Important: If ite X Burial 2 ☐ Cremation 3 ☐ Removal fro 5 of Heaven Cem. 11/05/10 Silver Spring, MD injury 4 Donation 5 Other (Specify) 21. Signat of Funeral Service Lio Snowden Funeral Home 22. Name and Address of Facility any 246 N. Washington St, Rockville, MD 20850 the mode of dving, such as cardiac or respiratory as 23a. Part 1. Enter the diseas , or comp shock, or heart failure. List only of Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of -burial physician a Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown been signed by the should be detached 9 Unknow ons contribution to death but not resulting in the underlying cause given in Part I. Part II. Other 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Division of Vital 26. Place of Death (Check only one) funeral director, Be ဂ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. May er of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\text{Yes} Natural 5 Pending Investigation ccident completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [To the I within 2 only one) 29d. Date signed Month, Day 29b. Signature and title 29c. License number me and addre completed cause of death (Item 23a) (Type

Registrar
DHMH 17 Rev 7/2009

State

31. Date

(Month, Day, Year)

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	Physici		Registrar 1. Decedent's Name (First, Middle, Annette Harri	-		Cei	rtificate o			2. Date of D Month 10/25	Day	Year		ne of Death
Western .	/Medio		4a. Facility Name (If not institution, 9 Holy Cross Ho	spital	mber)			er S	princ]	Мо	County of Death	ery	
	Funeral Director		5. Social Security Number 216-82-8971 Usual Residence of Decedent	Sex 1☐M 2√€F	7. Age (In yrs. last bird	hday) Yrs.	If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of B (Month, E	irth Day, Yea <i>r)</i>)6/6(nplace (St. Intry) ning	ton, Do
Marvland	Maryland a-f show	ctor	10a. State 10b. County	e Georg	e Land						-			de City Limits Yes 2 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 7922 Sheriff	Road				0785				zen of What Cou		
036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Even from out be notified at	by Fune	11. Marital Status 1★ Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 □Yes If Yes, Giv	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2▼ No Specify:			14. Race - America Black, White, et Specify: Blac		e, etc.	n,	
1215-00	within 72 ho iene. than "natur the Medical	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1		(Give life. I	dent's Usual Oc kind of work do. DO NOT use ret shier	cupation ne during m ired)	ost of worki	ing		nd of Business/l Private		
yland 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, La John Harriga	1				В	ernio	e (First, Middl Ce Ric	char	dson		
ore, Mary	Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Middical Experience any injury or other traumatic event, It is Middical Experience and Liber Diffied Migories.		19a. Informant's Name/Relationship Annstean Harr 20a. Method of Disposition	igan Da	ughter 92	Dispo	Rolli	ng V	iew I	Or LAN	20c. Lo	Md 20 cation - City or 1	706 Town, Stat	te
Baltimo	permit. Page Department Important: If any Injury of once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie	cify)	state River	da B	le Cre	mato	ary S	Servi	ce,P.	erdale, .A. B Mito		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	emplications that colly one cause on e	aused the death. Do i	not ent	ter the mode of	dying, such		177.7			Approx Interva	
	be executed ician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	с	(or as a consequence of				-					
.O. Box 687	the death certificate y the attending phys ched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 12No 9 □ Unknown	1 ☐ Live I	come of pregnancy birth 2 ☐ Fetal death nant at time of death lown		⊒Ectopic pregn ⊒Other <i>(specify</i>					23d, Date of del Month	livery Day	Year
rds, P.	tuires that the de n signed by the a	þ	Part II. Other significant condition Sepsis	s contributing to de	eath but not resulting in	the u	nderlying cause	given in Pa	rt I.			use contribute to □ No 3 □ Pr		_
Vital Records,	The law requires that the sate has been signed by the page 2 should be detached.	Completed	Vaginal Blo	eeding						24a. Wa aut pei 1 □Yes	opsy formed?	prior to death?		dings available n of cause of
Vital	Physician; Th r this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	Hospital:				Othor:		h (Check onl)	one)			
Vision of	Attending Phys death. ctor: After this y the funeral dir	Certification: To	1 Yes 2 XNo 27. Manner of Death Natural 5 Pending investiga 2 Accident 6 Could no determin	28a. Date (Mon		Fime o	f 28c. I	njury at Vork?		28d. Describ 28f. Location	e how injur	nd Number or Ri		Number,
	Hospita 24 hours Funeral stely fille	Medical Co	29a. Certifier 1 XCertifying (Check only one) 2 Medical E	caminer: On the b	e best of my knowledge pasis of examination ar ner stated.	e, deat	th occurred at the	ne time, date ny opinion,	e and place, death occur	and due to the time	ne cause(s e, date and	s) and manner as d place, and due	s stated.	use(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	l.	210		29c. Lic	ense numb	ər		29d. Da	te signed (Mont	h, Day, Ye	ear)

29c. License number Doo64343 29d. Date signed (Month, Day, Year) 10/25/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen RD Silver Spring, Md Yodit W. Negusse, M.D. 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 2010 8:29 p HUNTER Medical October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 1, 1926 Funeral 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 ★ F Days Hours Months Director 218-76-6844 84 Japan Usual Residence of Decedent and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland 10d. Inside City Limits Direct Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 E. 6th Street 21701 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) (unk) ဂ pe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bruckelmyer/daughter 8385 Revelation Avenue Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 11/3/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 MD 21029 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Recor INFARECT disease or condition resulting in death) MyconeDio Medical Due to (or as a consequence of): Examiner CARDIAC dystanetion Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): BRADY CARDIA Exami nding physician and use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Dav Year Pregnant at time of death as been signed by the a standard to a P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 2 X No Yes Hospital or Attending Physician: 25. Was case referred to medical after death.

Director: After this certific Be Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 M Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD MOD 70559 10.30-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Secust 7 +4 Frederick 400 St 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day usie isci 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death SAUSBUF KICATICO TENINSUUM 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year, 1 M 2 X F 75 Director 218-34-8722 march Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Princess 1 X Yes 2 No Maryland Anne Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U,S.A 21853 30587 Irving 5+ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private tamily Home Domestic 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mc Neil Robinson James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau S÷ 30587 Peggy Bess-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Hurlock, MD. Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ward F. H. Anthony ncess Anne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dee to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of) resulting in death) Last -burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 ptonths? Month Pregnant at time of death No 9 Unknown 9 Unknown P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and #tle of certifie led cause of death (Item 23a) (Type, Print)

State Registrar

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 COLONAL

29c. License number

Rising Sun MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 1445 PM November Alice Marie Husfelt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun Cecil Calvert Manor Healthcare Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 DM 2 K Days FEB 11, Year 921 Hours Min. Maryland 89 215-42-9235 Director Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County event, the Medical Examiner must be notified at Director 1 🌠 Yes 2 🗌 No Childs Cecil |Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 21916 United States 400 Star Route Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72.
Department of health and Mental Hygiene.
Important: If item 27 is marked other than "any injury or other transman." College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Religious Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Virdela B. Pleasanton Ernest M. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 5, 393 Star Route Road, Childs, MD 21916 George H. Husfelt/Son injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leeds Cemetery 13. 2010 <u>Leeds, MD</u> 22. Name and Address of Facility Hicks Home for Funerals, ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final arkinson Physician/ Rars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 9 Unknown cate has been signed by the a page 2 should be detached it P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 2**\Q** No 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 😭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

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within 2 To the

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State of Maryland / Department of Health and Mental Hygiene 36274 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician ģ P^{M} Okley Howard Ingram, Sr. 2010 1205 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Care and Rehabilitation Cecil E1kton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Vrs 90 Director 416-28-3998 AUG 10, 1920 Alabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Muchael Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Cecil E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23 Apple Lane 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 ဤYes 2 □ No If Yes, Give War II Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Paint Repairman Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer Ingram Sallie Gilliland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie P. Ingram/Wife 23 Apple Lane, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12, 2010 Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 Mamin Approximate
Interval Between
Onset and Death
Whk num 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sele consequence of led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physlcian: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 0 2023322 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) Sachder 8mi 11.10.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SSAddevMD 126 A, E High ST, Eleten MD 21921. 126 A, E thick ST 32. Registrate Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #1, 11/3/2010, per Dr., Collingate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dawn DeAnn Jonas Day Physician/ Month Year Decina 150 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Kentucky 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days May 30 , 1 M 2000 F Months Min. 1974 36 451-67-4436 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XXNo Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 Sherwood Glen 20794 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal any injury or other traumatic event, the Medical Exal Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde L. Jonas Judy Elkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M/M Clyde Jonas Parents 115 River Point Dr. Yorktown, VA 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Ardent Cremation 11/3/2010 4 ☐ Donation 5 ☐ Other (Specify) |Hanover, Maryland Signature of Funeral Service Acenses 22. Name and Address of FacilitHarry H. Witzke's Family FH, Inc. V-1-4112 Old Columbia Pike Ellicott City, MD 23a. Part L'Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequent) of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 ending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year the. 9 Unknown P.0. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cardial Records, Hospital or Attending Physician: The law require: 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DIMIN DING K. 5 page 2 autopsy performed' death? 2 🖅 No Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖳 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Tyes 24 hours after death. Funeral Director: A Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 66 515 Nev 02 2010 Howard Co. General Hospital 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CedarLA Columbia Mid 21044 12 31. Date filed (Month, Day, r 32. Registrar's Signature State arke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 36276 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Jeffre ugene Medical ZOR 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore</u> 6. Sex 1X M 2 F 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth
Jan. 30 Year) 953 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days Hours Director 57 Washington, DC 212-64-0119 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Md. Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20720 12326 Lanham Severn Road 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black Armed Forces? by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Phone Technician Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ Hattie Gross Ernest Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12326 Lanham Severn Road Lanham, Maryland 20720 <u>Pamela Jenkins/Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from 11/8/2010 Landover, Maryland Harmony Cemetery Donation 5 Other (Specify) signature of Funeral S 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 7474 Landover Road Hyattsville, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition to Thenv Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading Limm later cause. Enter Underlying Cause (Disease or iinjury that initiated events to talente Examiner Due to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed own Cancer resulting in death) Last Due to (or as a consequence of): Physician/Medical Colon Division of Vital Records, P.O. Box 68760 Cancur IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate Yes 2 No 2x No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ucertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar 2899526

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/29/2010 RAE-NAE JOYCE JOHNSON Medical 6:15 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours 02/05/1956 219-68-3274 **Director** 54 Usual Residence of Decedent 10a. State items 23a or 28a-f sho ner must be notified at the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Beltsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 3313 Bunnington Road 20705 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes : 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Payroll & Benefits Specialist RLJ Companies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LeRoy Alvin Johnson, Sr. Jerlean Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17403 Old Baltimore Road, Olney, MD 20832 James R. Wardrick, Jr. - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from 4 Domation 5 Other (Specify) of Heaven Cem. te 11/04/10 Silver Spring, MD 21. Signature of Funeral Service Lid 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Postobstructive pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metastatic breast cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events coulding in death). Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Year detached 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 其 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 🔊 death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29c. License number Wo D0064100 10/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji 1500 Forest Glen Road, Silver Spring, MD 20910 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f. Per FH G923, 1/27/2012, JH. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ William Edwards Knight 11/3/2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Prince George's Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🕅 M 2 🗆 F Months Days Hours Min Country)
Tareytown, NY 88 Director 125-03-9611 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director DC MD Prince George's Mitchelville 1 X Yes 2 No Washington 10f. Zip Code 10e. Street and Number 10450 Lottsford Road 4714 Albemarle Street, 10g, Citizen of What Country? Funeral 20721 20016 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 No Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–45 1 ☐ Yes 2 X No Specify: ian "natural", Medical Exan Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the US Government Diplomat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Octavius Knight Mable Jenkins 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4714 Albemarle Street, Washington, DC Peter Knight / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Department of Important: If any Injury or Metropolitan Crematory 11/6/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to wr as a consequence of Examin and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I δ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Prostala Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 X No 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medica 26. Place of Death (Check only one) director, Be Hospital 2 No Other: 1 Yes ပ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural work? 5 Pending nours after death.

neral Director: Aff 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) To the Hospital within 24 hours a To the Funeral I completed filled Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manash Das, 3001 Hospital Drive, Cheverly, MD 20785

68964

29d. Date signed (Month, Day, Year)

2010

31. Date filed (Month NOV 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Hope A. Kane Hope A. Kane 4a. Facility Name (if not institution, give street and number) Casey House Funeral Funeral Hope A. Kane 4b. City, Town, or Location of Death Rockville Funder 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Month, Day, Month, Day, Year Month, Day, Year Month, Day, Year Month, D	Day Year 28, 2010 3. Time of Death 6:00 P M 4c. County of Death Montgomery 9. Birthplace (State or Foreign County) Washington, DC
Physician/ Medical Examiner Hope A. Kane 4a. Facility Name (if not institution, give street and number) Casey House Funeral Funeral Ab. City, Town, or Location of Death Rockville S. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Month October 2 4b. City, Town, or Location of Death Rockville Funeral Month October 2 4b. City, Town, or Location of Death Rockville Month Days Hours Min. Month Days Hours Min.	Day Year 28, 2010 6:00 P M 4c. County of Death Montgomery 9. Birthplace (State or Foreign County) Washington, DC
Hope A. Kane Hope A. Kane 4a. Facility Name (if not institution, give street and number) Casey House Funeral Funeral Hope A. Kane 4b. City, Town, or Location of Death Rockville Funder 1 Year If Under 24 Hrs. B. Date of Birth Month, Day, Year Month, Day, Month, Day, Year Month, Day, Year Month, Day, Year Month, D	28, 2010 6:00 P M 4c. County of Death Montgomery 9. Birthplace (State or Foreign Country) Washington, DC
Casey House Casey House Funeral S. Social Security Number 6. Sex 1	Montgomery 9. Birthplace (State or Foreign Country) Washington, DC
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yea	9. Birthplace (State or Foreign Country) Washington, DC
Funeral Month, Days Hours Min. (Month, Day, Yea	945 Washington, DC
Director $ 5/8-64-68/5 $ 65 115 Aug. 9. 10	
Havel Paridance of Decedent	
10c. City, Town or Location	10d. Inside City Limits 1√X Yes 2 □ No
7	Citizen of What Country?
MD Montgomery Rockville 10c. City, lown or Location Rockville 10c. City, lown or Location Rockville 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. Street and Number 10c. City, lown or Location Rockville 10c. City, lown or Locat	USA
5801 Nicholson Lane #1801 20852 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
3 ☐ Widowed 4 ☐xDivorced If Yes, Give 1 ☐ Yes 2 ☐xNo Specify: Year or Dates.	Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	. Kind of Business Industry
3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker	Own Home
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid-	en Surname)
Rose Dorman Rose Dorman	
Solution	
Kevin Kane/Son 11029 Rosemont Drive, Rockvi	
20a. Method of Disposition 20b. Place of Disposition (Name of cere) 20c.	:. Location - City or Town, State
4 Donation 5 Other (Specify) Remembrance 10/31/2010 C1 を表す。 121. Signature of Funeral Service Licensee 222. Name and Addres Edward Sage1 Funer	larksburg, Maryland
20d. Method of Disposition 1 1 2 Cremation 3 Removal from State 20d. Place of Disposition (Name of 1) 20d. Method of Disposition 1 2 Cremation 3 Removal from State 20d. Place of Disposition (Name of 1) 20d. Place of Di	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate
shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lung Cancer disease or condition Lung Cancer	Interval Between Onset and Death
Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b.	
if any, leading to immediate Due to (or as a consequence of):	
that initiated events c. resulting in death) Last Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
W IF FEMALE:	
23b. Was decedent pregnant on the past 12 months?	23d. Date of delivery Month Day Year
FFEMALE: 23c. If yes, outcome of pregnancy 1	Month Day real
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	co use contribute to the cause of death?
2	2 No 3 Probably 4 Unknown
De le de la	24b. Were autopsy findings available prior to completion of cause of
24a. Was an autopsy performed 1 Ves 2 12	death?
25. Was case referred to medical examiner?	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	6 XOther (Specify) Hospice
5 6 5 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	njury occurred
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4 Homicide determined building, etc. (Specify)	tate)
So To Be to	and manner as stated. ace, and due to the cause(s) and manner stated.
	se(s) and manner as stated. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	tober 29, 2010
Debrah Miller, CNP,6001 Muncaster Mill Road, Rockville, Maryla	and 20855
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

10-08251 Oliver Darvl Kirk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Onver Daryr (n		1- For State Control of Manyland / Department Certificate		Reg		36280				
Physic Medical Exam		Decedent's Name (First, Middle,Last) OLIVER DARYL KIRK		2. Date of Death Month C October 28,		3. Time of Death 1746 hrs				
		4a. Facility Name (if not institution, give street and number) 5007 Saint Simon Court	4c. County of Death Frederick							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MWDD/YYYY) 9. Birth (21) 2 7 6 0 0 0 2								
Director		Usual Residence of Decedent	Yrs. Months Days Hours Mi	01/12/	1959 Cou					
ow any		10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits				
Maryland 28a-f show d at once,	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	1 Yes 2 No				
ith the N 23a or 2 notified	al Dir	5007 SAINT SIMON CT. 11. Manital Status 12. Was Decedent Ever in U.S. 13.	21703		USA					
3, MD 21215-0036 Leath and Mental Hygiene. Tem 27 is marked other than "natural", or items 23a or 28a-f short rammatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 No specify:	o Rican, etc.)	14. Race - America White, etc. American Specify:	Indian				
2 hours "natul			dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		6b. Kind of Business/Inc	dustry				
215-0036 be filed within 72 hours after ntal Hygene. rked other than "natural", ent, the Medical Examiner.	Completed	4 SYS	STEMS ENGINEER		COMPUTE	R				
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) ARGYLE KIRK		e (First, Middle, Mai DIAMOND	iden Surname)					
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	Σ		iling Address (Street and Number or) 7 SAINT SIMON							
Ore, Nes 1 and of Healt If item		20a. Method of Disposition 20b. Place of Disposition	position (Name of cemetery,	Date 2	20c. Location - City or To	own, State				
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify.	ER CREMATORY 11							
		A. Du	HILTON FUNERAL	Bi	.O. BOX 8	E, MD				
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Wound of Chest		or respiratory arrest,	, snock, or heart	Approximate Interval Between Onset and Death				
Adminier		or condition resulting in death) Due to (or as a consequence of): b.				-:-				
	Examiner	if any, leading to immediate Due to (or as a consequence of):								
uted Id ransit	Exar	events resulting in death) Last Due to (or as a consequence of):				1				
x 68760, h certificate be executed tending physician and use as the burial - transit	edica	UNPENDED X AMENDED #14per FH, G910	,12/16/2010,WS							
Sox 6876 leath certificate e attending phy for use as the l	an/M	past 12 months?	Fetal death 3 Ectopic pregna		23d. Date of delivery Month Day	/ Year				
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)							
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Division of Vital Records, P.O. Box Ital or Attending Physician: The law requires that the death rs after death. al Director: After this certificate has been signed by the atter led in by the funeral director, page 2 should be detached for u	Completed			24a. Was an autopsy		osy findings available inpletion of cause of				
tal Rec		25. Was case referred to medical		performe 1 Yes 2		2 No				
n of Vital F ding Physician: n. After this certifi funeral director,	o Be	examiner? 1 Yes 2 No	26.Place of Death (Check ent 3 DOA Other, Nursin		sidence 6 🗸 Other: S	cene				
ion of Vii tending Physic eath. tor: After this the funeral dir	ioi	27. Manner of Death 1 Natural 5 Pending Pound: 28a. Date of Injury (Month: Day, Year) FOUND: Pound: FOUND: Pound: FOUND: Pound: FOUND: Pound: FOUND: Pound: FOUND: Pound: Found:	of Injury 28c. Injury at Work?	28d. Describe how Subject shot se						
Divisior To the Hospital or Attency within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation 3 ✓ Suicide 6 Could not be Oct 28, 2010 1730 hrs 28e. Place of Injury - At home, farm, sti	reet, factory, office building, etc.	28f. Location (Stre	et and Number or Rural	Route Number, City				
Divis To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by		4 Homicide determined (Specify) Single Family Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ			n Ct, Frederick, MD					
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	gation, in my opinion, death occurred a	t the time, date and	place, and due to the o					
		29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Month</i> October 29, 2010	, Day, Year)				
	+	30. Name and address of person who completed cause of death (Item 23a)	0							
Si	ate	31 Date filed (Moeth Day Veerly - 32 Physician Cignature	Street, Baltimore, MD 21201							
Regist	rar	31. Date filed (Modiff) Text, Year 1 2010 32. Hagistrar's Signature	Carles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Or Tober Richard Lee Lucas, Jr. 1542 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince If Under 1 Year If Under 24 Hrs. Trince Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth July 16,1954 Birthplace (State or Foreign Country) NC **Funeral** Months Min. 245 92 8636 Director 56 Usual Residence of Decedent Show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA Loudon 1 X Yes 2 No Sterling 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1009 North Amelia Street USA 20164 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Black, White, etc. should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leroy Brown Mildred Lucas 19a. Informant's Name/Relationship (Type, Print) Brenda Dawes/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i <u>1719 Center Street Wilson, NC 27893</u> Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H 1 Burial 2 Cremation 3 Removal from State Rouse Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2010 Greenville, NC Edwards Funeral Home 21. Signature of Funeral Service Licent 22. Name and Address of Facility 805 East Nash St. Wilson, NC 27894 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotie Cardiovascular Heart Dise Physician/ Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Due to (or se's consequence ory if any leading to immedicause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? this certificate 1 Yes 2 No Yes 2 - No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending 1 Tes 2 🗌 No Investigation 24 hours after death completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2

Box 68760

P.O.

Records,

Division of Vital

233

Registrar

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1-20

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32. Registrar's Signature

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3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36282 State
Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jennie Catherine Littleton Month 0 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COASTAL HOSPICEAT WICOMICO DALISBUR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🔼 F Hours 218-01-1186 94 Director 0/11/1916 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Maryland Powellville 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 5359 Powellville Road 21850 USA ral", or items ? L'Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) seamstress clothing manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Johnny F. Morris Daisey Alice Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4296 Elk Creek Dr., Salisbury, MD 21801 Jennie Osborne/daughter Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jones Cemetery 11/3/2010 Powellville, MD Holloway Funeral Home Professional Association Dompor CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Arteriosder disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dus to (or as a consequence of). attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No completed filled in by the funeral director, page 2 should be detached for Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate h 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗶 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospical Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at To the Hospital or Attending within 24 hours after death. 1 X Natural 5 Pending injury work? 1 \(\text{Yes} \) 2 \(\text{No} \) Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 10-31-2010 29505 legarer M.

-ym

DHMH 17 Rev 7/2009

State

Registrar

5302 CHINABERRY DR., SALISBURY, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELL

GREGORIO

Day, Year)

4

050

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36283 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER Year 0420 RANDOLPH LEWIS AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Month Day, July 18, **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Year 960 Washington, D.C. Director Yrs 139-56-3659 50 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 x Yes 2 ☐ No Maryland Prince George's District Heights 10e Street and Number 10g, Citizen of What Country? with 1 Funeral 2413 Senator Ave. 20747 death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces 1 X Never Married 2 Married þ 1 ☐ Yes 2 √ No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: "natural" 3 Divorced 4 Divorced **Black** Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Store Clerk Private traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Randolph Lewis Elizabeth Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Lewis / Brother 2413 Senator Ave. District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 KX remation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan 11/3/2010 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. M00981 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Interval Between Immediate Cause (Final Onset and Death Physician/ FATAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner STAGE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lilled in by the funeral director, page 2 should be detached for use as the burnal-transit completed lilled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d, Date signed (Month, Day, Year) 155220

Registrar
DHMH 17 Rev 7/2009

State

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HOSPITAL

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32. Registar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATIN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day JOHN CALVIN LANDON, JR. 3:21 P M October 2010 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** McCready Memorial Hospital Crisfield Somerset 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F 216-40-3656 Director 67 11/16/1942 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or on one; in iny or other traumatic event. Its Maryland one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset 1 ☐ Yes 2 🛣 No Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31105 Old Rehobeth Road 21871 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status I ⊠Yes 2□No 1960-f Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1986 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Instructor/Squad Leader/Supervisor United States Army 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Calvin Landon Elaine Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Landon (Wife) 31105 Old Rehobeth Road - Westover, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 12/22/2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of uneral Service Llouise 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshaw, Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician unter disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) sician and burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the g detached f 1 ☐ Yes 2 ☐ No. 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has page 2 s autopsy performed Yes 22 No certificate I 1 □ Ýes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physiclan: within 24 hours after death.

29b. Signature and title of certifier 19

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

D-39813

November 1, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

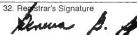
M. Atkins, M.D. - 201 Hall Highway - Crisfield, MD 21817

State Registrar

Medical

(Check only one)

31. Date filed (Month.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 30 tIMA 11:30A M 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ucen Anne's Hospice ce Center
7. Age (In yrs. last birthday entreville Queen Annes 6. Sex Birthplace (State or Foreign Country) ocial Security Number Year If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** Months Days Min. 1 ☐ M 2 🔀 F Hours 095-22-5539 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Pres 2 □ No Director Annes eens town Ma. Ueen 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5714 USA 14. Race - American Indian, 21658 Funeral main 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2☐ No Yes, Give 1 ☐ Yes 2 No Specify: þ If Yes, Give ' Year or Dates: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Kegistered incoln 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Wilson reorge Wash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Main Street Wright-daughter 5 ucenstown, md. 21658
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 22. Name and Address of Facility

Bennic Smith Funeral Home

426 Dover Street, Easton, md. 2

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final disease or condition) 4 Donation 5 Dother (Specify) md. Veterans Cem. 11-05-10 Hurlock, Md. Easton, md. 21601 Approximate Interval Between Onset and Death ulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tral Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Uhknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes No After this certificate has 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registra

29b. Signature

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

NOV 0 1 2010

M.D

32. Registrar's Signature

555

29c. License number

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER Physician/ 27,2010° RICHARD LEATHERMAN LEE 9:00P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Months 1 🔀 M 2 🗆 F 217-28-6946 Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 X No MD Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5013 Gapland Rd. 21758 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1946—

1 No 1946—

If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: White XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 construction carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Leslie D. Leatherman Nellie M. Leatherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2176 Harmonia Rd., Warfordsburg, PA 17267 Donald Lerch (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of Confederation, Sistanta, Orlotte Colace) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 10/31/10 Church Cemetery Myersville, MD nature of Funeral Serv ²²Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death te Oruse (Final Physician/ (NFARCHON MYO (AND (AL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? Month Dav Year 1 Yes 2 No 9 Unknown To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ney monin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cake Himahin Failly me 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicid 1 Yes 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

To the within 2

State Registrar (Check

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kinland Mis

2010

DHMH 17 Rev 7/2009

613 32. Registrar's Signature NINM

anke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D22037

Brunwill M

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 36287 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician NOVEMBER 14 10 ${ t ALBERT}$ KIENZLE LUDY 6:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15525 POTOMAC RIVER DRIVE COBB ISLAND CHARLES 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Hours Min 90 Yrs Director 372-20-2005 MAR. 21, 1920 ALASKA Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Evat. The Coust be notified at Director 1 ☐ Yes 2 XNo MD CHARLES COBB ISLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15525 POTOMAC RIVER DRIVE 20625 S. Funeral Α. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ∐Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ECONOMIC & COMMERCIAL OFF. FOREIGN SERVICE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT KIENZLE LUDY ETHEL MAE ALBRECHT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLIE J. LUDY/DAUGHTER POTOMAC RIVER DR.COBB ISLAND, MD 20625 15525 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State METRO . CREMATORY 16,2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 Eru 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final e88 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24a. Was an autopsy performed 1 □Yes 2 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s certificate 2 No Division of Vital 1 Tyes 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only one) daughters home Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 6 Other (Specify) this funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No hours after death uneral Director: A 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in TIL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Reg

30. Name and address of

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32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Pri

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . Month Year 2010 2053 MARY ELIZABETH LOMAX November Medical 4a. Facility Name (if not institution, give street, and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Memorial HOSPITAL TAL BOT EASTON 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day, Year) 3/9/1947 1 □ M 2 🔀 F Days Hours Min Yrs Director MARYLAND 218-50-1380 63 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND CAROLINE DENTON 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral with **26815 BAKER RD** 21629 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No **Maryland 21215-0036** If Yes, Give Year or Dates 1 ☐ Yes 2 No "natural", Specify 3 ₩ Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COPY ROOM CLERK PRINT MEDIA Be other traumatic event, permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important; If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SHREVE MORRIS ANNIE FAULKNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE LOMAX / DAUGHTER-IN-LAW 31333 DUKES BRIDGE RD., CORDOVA, MD 21625 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY AT GREENLAWN CEMETERY 11/9/2010 CAMBRIDGE, MD Signature of Funeral 22 Name and Address of Facility 0 CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequent of): Examiner na equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year isigned by the a Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 No Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital Other: <u>ا</u> 1 Yes No 12 Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident

Suicide

Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009 3 20

State Registrar

Signature and

30. Name and address of person who

31. Date filed (Month, Day, Year

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use of death (Item 23a) (Type, Print)

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s Signature

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32. Registra

License number

Hospital, Eastons

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			1 - For State Registrar	State of M	laryland / D	epartmen Certificat			nd M	-	giene Reg. No.	10	36289
6.2	Physic	ian	1. Decedent's Name (First, Middle Holls & T.	c mills						2. Date of De Month	Day	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution		,		La	, ,,,,	ta.		4c. Cou	nty of Death	es.
	Funeral Director		5. Social Security Number 216 05 3836 Usual Residence of Decedent	6. Sex 1 □ M 2 ☑ F	ge (In yrs. last birti 97	Months Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Dec 21,	1912	9. Birthi Cou Wash	place (State or Foreign ntry) ington DC
	e Maryland Ba-f show	ctor	10a. State 10b. County MD Pri	nce George's	10c. City, Town	or Location Bladensbur	g						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	s or 2	i Dire	10e. Street and Number 5999 Emet	rson Street 508		1 Of. Zip	Code 20710)			10g. Citizen of United		ntry?
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int. The Medical Exemirar must be notitined at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?	13. Was Deced	cify Cuba	spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	pecify Yes or No- Pican, etc.) 14. Race - A Black, W Specify:			
21215-0036		Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-4or	5+)	Decedent's Usua (Give kind of wo life. DO NOT us Secertary	rk done a	luring most	of workii	ng	16b. Kind of	Business/In	•
Maryland	be d la	To Be (17. Father's Name (First, Middle, William Mills	Last)					,	(First, Middle, Unknown)	Maiden Sum	ame)	
Mar	2 E 20 E		19a. Informant's Name/Relations John Schlosser (r.		19b.	Mailing Address 713 Bryar						vn, State, Zij	Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 M Cremation 4 □ Donation 5 □ Other (S	pecify)	'	Disposition (Nary, crematory or o	ne of ther place No	ov 2, 2	010	ate	20c. Locatio	n, Mary	land
8	P P P P P	Toyle & Magen 963 Ferry Road, Clinton, MD 20735											Approximate
.760,	Physician / Medical Examiner physician and physician who privial-transit	i Examiner	23a. Pan Ener W dissect or shock, or hent fail ne. List Immediate Cause (Final disease or coyolition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or a b	gen	ces u	oite	ρθ	8 5 i	ble	netas	tasis	Interval Between Onset and Death
.O. Box 68	death certific e attending pl d for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 □Ectopic pr 5 □ Other (sp						Date of deliv	ery Day Year
rds, P	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions (COPD), Hy	ons contributing to death	but not resulting in	the underlying c	ause give	en in Part I.	ς.		obacco use co Yes 2□No		he cause of death?
Vital Records,	The la ete has page 2	Completed	reflux o	bsis, a	iant	resopt	rag	eal		24a. Was autor perfo 1 🗆 Yes		b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
Vit	Physician: Th this certificete al director, pag	To Be	25. Was case referred to medical examiner 1 Yes 2 No	Hospital:	ent 2 ER/Out	patient 3 DC	Othe			_(Check only only only only only only only only		Other (Sneci	fv)
Division of	After fune		27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	g 28a. Date of Inj (Month, Di	ury 28b. T		8c. Injury Work	at	2	28d. Describe			,,
Divis	ital or Att rs after do al Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286. Place of Ir	jury - At home, far tc. <i>(Specify)</i>	m, street, factory	r, office		2	28f. Location (City or To		mber or Run	al Route Number,
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	ledicai	29a. Certifier 11 Certifyin (Check only one) 1 Medical	g Physician: To the bes Examiner: On the basis and manner s	of examination and	death occurred Vor investigation	at the tim , in my op	e, date and pinion, death	place, a	and due to the ed at the time,	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
)	with To	Σ	29b. Signature and title of certifier	Tulu	2_			071		j.		02/11	
4	137		30. Name and address of person Os Josin Von 31. Date filed (Month, Day, Year)	who completed cause of	mn (Item 23a)	#57 T	de	San	15 (Mon	1 100%	re 1	A .
	Sta Registi		31. Date filed (Month, Day, Year)	3 2010 Jenu	rar's Signature	park	/	}					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 8:05P M 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Salis the Hospice at wicomico DUT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days 1**⊠**M 2□F 375-30-7484 Usual Residence of Decedent Director -30-1933 m 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director VΑ ccomack sreenback vill 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Jolly Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces:
1 Zi Yes 2 No
If Yes, Give
Year or Dates: 1952-1956 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Mo Specify: 9 White Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Penn Fishing Manager 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be B. Martin ပ Helen Cappicotto Hnderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Numbe, C ty or Town, State, Zip Code) Moger Greenback wille, VA 23356 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Exmore, VA Occohannock Cremotery 3-2010 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chincoteogue, VA 2333L Botter Home Inc. 6327 Church -une ral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC Physician KIDNE DISEASE /Medical Due to (or as a consequence of): Examiner HYPBRTENSON Coquentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed DIABRTRS physician ar s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: ျ 2 ER/Outpatient 3 DOA 4 Nursing Home Other (Specify) 5 Residence 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director; Af 1 Yes 2 No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 33 2/802 6 Huchu 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State NOV 0 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 McCallister Minnie 4:45 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George Clinton Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** North Carolina 1 🗆 M 2 🔀 Months Days Hours Min Director 101 228-23-0187 Usual Residence of Decedent or 28a-f show be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 3113 Channing Street NE 20018 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give n "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. sant: If item 27 is marked other than ury or other traumatic event, the Ms Elementary/Seconday (0-12) 5th College (1-4 or 5+) Cook Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peggy Moore Funny Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Channing Street NE Washington, DC 20018 Carolyn Davis - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 10 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Fort Lincoln □ Donation 5 □ Other (Specify) 2010 Brentwood, Maryland . Sig ature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Presumonia Onset and Death Physician, Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending by the Internal Director, page 2 should be detached for use as the burnal-transit ated filled in by the Internal director, page 2 should be detached for use as the burnal-transit been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mont Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital Other: |은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural (Month, Day, Year) 5 Pending injury 2 Accident
3 Suicide Investigation

Division of Vital Records, P.O. Box 68760

State Registrar

1328 Southern Grenne SE Juste 310 Palmer MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

ss of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

4 \square Homicide

29a. Certifier (Check only one) 29b. Signature and title of g Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medica/Expininer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

WAShinghonDC

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 30, 2010 7:55 A M McElroy Joseph P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 16107 Amethyst Lane Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug 15, 1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Pennsylvania **Director** 577-48-9000 73 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16107 Amethyst Lane 20716 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1959-63 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry . Page 1 and 2 should be filed within 72 trnent of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Asbestos Worker Mechanical Insulation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ O'Donnel William McElroy Miriam Angela George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol McElroy/wife 16107 Amethyst Lane Bowie, Maryland 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/3/2010 Woodbine, Maryland Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 9 months Immediate Cause (Final Physician/ Mesothelioma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has lead to the funeral Director. сотрыет filled in by the funeral director, page 2 performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Projection in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 151260 10,29,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 154 Barry Meisenberg, 2001 Medical Parkway Annapolis, Maryland 21401
32. Rejistrar's Signature M.D. 31. Date filed (Month, Day) 0 3 2010 State Registrar

DHMH 17 Rev 7/2009

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV 2010 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7421 Cherry Tree Dr. Fulton Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Date of Birth 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 M 2 D F Min. Hours Director 225.52.330 69 D.C Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7421 Cherry Tree Dr. 20759 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 XNo If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: and Mental Hygiene. is marked other than "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer JH Applied Physics Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Limportant: If item 27 is marked any injury or attention ပ William Thomas Mason Rose Lilliston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Mason / Wife 7421 Cherry Tree Dr., Fulton, MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation 11/2/2010 Hanover, MD 4 Donation 5 Other (Specify) M01411 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Ser Or 7 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the diseast or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No or Attending Physician: 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျှ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 12366507 of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month OCTOBER Physician/ 2010 LOIS LAURETTE MULLINTX 9:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last hirthday) 8 Date of Birth Funeral Days Hours Min Maryland 1 □ M 2 🗓 F 88 1922 Director 217-18-7005 Usual Residence of Decedent 28a-f shov 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director TX Yes 2 No Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1703 South Main Street 21771 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 🛣 No If Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: marked other than "natural", Specify: Completed 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert W. Mullinix Edith Mable Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 W. Leon Mullinix - Husband 1703 South Main Street, Mount Airy, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chapel Cemetery 11/5/10 Mount Airv. Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Preumoni -spiration disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami and -transit that the death certificate be executed ementio Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined In 24 hours,
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Registrar DHMH 17 Rev 7/2009

State

Box 68760

Frederick MD 21701

74h St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W

32. Registrar's Signature

Execuse

Liana

10-08574 Janette A. McLaren

Replease Type Eine in Black Indelible Ink. Ensure All Copies Are Legible.

anette A. McLare		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010 36295													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Hosp	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Exar	niner: On the ba	sis of examinat	tion and/or invest	occured at the time tigation, in my opini- death occurred at th	on, death	occurred at	the time, date	and place	e, and due to the	cause(s) and manner stated.			
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	BA 19+1		30, Name and addres	Health	Way K	y. <		Print) Hoteline	ح, ۲	· (D.)	B	uli	ri, mi	D 21811			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Month 3 Pay 2010 6:30 A M Irene M. Nissel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8329 Church Lane Ellicott City Howard If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Year 1933 1 🗌 M 2 🕱 F Months Days Hours Min. May 29 Director MD 216 32 0149 77 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Ellicott City MD Howard 10e. Street and Number 10g. Citizen of What Country? Funeral United States 8329 Church Lane 21043 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2X Married δ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygien Hostess Funeral Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be file
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Eugene Meyer Irene Carper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Thomas Nissel/Husband 8329 Church Lane Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Good Shepherd Cem. 11-4-2010 Ellicott City, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 - Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Dancrea disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the bunal-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K N certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🛛 Residence 6 🗌 Other (Specify, 1 \sum Yes 2 X No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident
Suicide within 24 hours after death.

To the Funeral Director: Af 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

8

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chrocede

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Day ROBERT LEE O'FERRALL, SR. 11:15 AM 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** is bu Nicomico Year If Under 24 Hrs. If Under 1 Date of (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** Age (In 1**X**□ M 2 □ F Director 213 22 8270 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo Maryland Wicomico Willards 1 🔀 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 36098 Lumberyard Lane 21874 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinancines. Completed by 1 Never Married 2 X Married 1X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2X☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1948-52 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) <u>Airplane Mechanic</u> Airline Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O'Ferral1 Elsie Virginia Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Jean O'Ferrall 36098 Lumberyard Lane Willards, MD 21874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 \square Cremation 3 \square Removal from State Dale Cemetery 11/6/10 4 Donation 5 Other (Specify) Whaleyville, MD 21. Sign of Funer 108 William St. 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. nterval Between Immediate Cause (Final Onset and Death HB1MR Physician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ☐ No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: Hospicer 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at work? Certificate: 5 Pending after death. Accident
Suicide
Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Gentifying Nurse Practioner: To the best of my knowledge, dieth constraid at the time, date and place, and due to the deuse(s) and manner as stated 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) D80584C0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) DN 5+1 o Huyan WARIS 150 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Novembe Physician/ Year 7:31 A M Virgilio D. Ortiz 2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Doctors Community Hospital Lanham 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours Min Days Director 80 Dominican Republic 156-80-8757 Usual Residence of Decedent 28a-f shor 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3613 14th Street, N.W. 20011 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. ð 1 Never Married 2 X Married 21215-0036 1 ☒ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Specify: Completed Dominican Latino 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 3 Housekeeper Poretsky Management Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Geronimo Ortiz Clara Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Esther Neira / Daughter 10107 Madronawood Drive, Laurel, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗌 Cremation 3 🗋 Removal from State Funeraria 'La alta gracia' 11/13/2010 Dominican Republic 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue (MB) Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -trans and Due to (or as a consequence of) resulting in death) Last attending physician if for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 2 🗌 No 1 Yes 25. Was case referred to medica the funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: Certificate: To ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 11/3/10 ne and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good huck Rd., Lanham, MD. 20106

DHMH 17 Rev 7/2009

State Registrar rns

, MD.

10-08284 David Oughton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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212 ould be Menta market	To Be	19a. Informant's Name		pe, Print)		19b. Mailing	Address (St		er or Rural Route N		ty or Town, S	State, Z	(ip Code)
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Gate of Heaven Cemetery 2010 Silver Spring, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility										, MD	
Ba perm Depa Impe injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901											1
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Box 68760 e death certificate b the attending physical for use as the bu	ician	past 12 months?		1 Live birth 4 Pregnant at t	ime of dea	ath 🗀	Ideath :	3Ectopic p	pregnancy	'	Month	Day	y Year
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/iSior r Attenc rer death rirector: n by the	ficat	2 Accident 3 Suicide 6	Investigation Could not be	28e Place of Init	ıry - At hor	me, farm, street,	factory, office		28f. Location		d Number of	r Rural	Route Number, City
Div spital o ours af filled i	Certi	4 Homicide	determined	(Specify) Loca	al Stree	t			or Town, Chandlee Ro		Goldmine F	Road,	Sandy Spring, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit									e, and due to the cau				ause(s)
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			For State	State of Mary				Mental Hy	giene			
		_	Registrar		Cer	tificate of <i>E</i>)eath		Reg. No. 2010 2020			
	Physicia		1. Decedent's Name (First, Middle, Last) AUSERT FAR	AN CIS	10	TNAM		2. Date of Dea Month		3. Time of Death		
واستحابر	Medic Examin		4a. Facility Name (if not institution, give sti Howard County Gene	reet and number)		4b. City, Town, or	Location of Dea		4c. County of Howa	Death		
	Francis		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	s. 8. Date of Birt		. Birthplace (State or Foreign		
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ဖွ	ter dea , or ite	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2¾☐ No	1	f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, \	American Indian, White, etc.		
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ary	nould Me s mari	9	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	g Address (Street a			r, City or Town, State	e, Zip Code)		
Σ	nd 2 sl ealth a m 27 i		Paul E. Putnam-fat	her	13 C	luf Bay R	d., Bru	nswick, l	ME 04011			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, cren Stauffer	natory or other plac		Date 04/2010	20c. Location - Cit Frederick			
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687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of p					23d. Date o	of delivery		
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at tim		Dectopic pregnance Other (specify)	У		Month	·		
P.0	s that the	þ	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?		
rds,	equire	eted								☐ Probably 4 ☐ Unknown		
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Ž	Physic this or al dire	၉	1 Yes 2 ☐ No Ho 27. Manner of Death	spital: 1 Inpatient 28a. Date of injury	2 ER/Outpatien		4 LJ Nursing		dence 6 Other (S	Specify)		
o uo	ending leath.	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Ye		28c. Injury work M 1 □		28d. Describe h	low injury occurred			
Divisi	tal or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,		
	te Hospit n 24 hour se Funera	Medical	29a. Certifier (Check 2 Medical Examine only one) 3 Certifying Nurse l	r: On the basis of exam	ination and/or invest	igation, in my opinio	n, death occurred	d at the time, date a	nd place, and due to	the cause(s) and manner stated.		
_	To the complete compl	-	29b. Signature and title of certifier			29c. License	number		29d. Date signed (M			
			Com Aly	M		2005	13051		NOY 1	2010		
	10		30. Name and address of person who con Walter Fleming Ath		, , , , ,		. MD 210	042				
)	Stat		31. Date filed (Month, Day, Year)	32. Registrar's 8		parke	,					
	Registra	r	NOV 42	2010 Denen	in B.	La alle						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Day 0/2:57 Parterson TARRIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rd 2818 Social Security Number 6 Sex Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country) Days Months 1 M 2 Hours Min. (Month, Day, Year) Director 0965 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Completed by Funeral Director 1 Yes 2 No Hughesville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Grossta 12818 USA 20637 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. 9 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", If Yes, Give 3 D Widowed 4 Divorced Specify: Black Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nurse 12 Medica Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gress JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i 1 Jorgay 20677 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State MARY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on beach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MONTH Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Pregnant at time of death Day Year 5 Other (specify) ed by the a detached f Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe certificate 2 N Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Investigation 1 🗌 Yes 2 No Accident 3 Suicide
4 Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practionar: To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rachel D. Price 2010 OctobER Medical Facility Name (if not institution_give street and number) 4b. City, Town, or Location of Death of Death **Examiner** 4c Ŏ. If Under If Under 24 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Birtny Country **Funeral** 1 □ M 2 🖵 F Months Days 66 217-42-5123 Director June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If finan 27 is marked other than "natural" 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1x Yes 2 ☐ No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 316 Cherry Way USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et ě 1 Never Married 2 😾 Married Yes 2 No Yes, Give African-1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Board of EDucation Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leila Roberts Charles Fields, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Cherry Way, Salisbury, MD 21804 Leonard A. Price/husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill
Memory Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/06/10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach if e. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 1 Yes 2 No been signed by should be detac Part II. **Other significant conditions** contributing to death but not be sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2.X No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature an 29d. Date signed (Month, Day, Year) 2010 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOMAS Registrar's Signature State Registrar

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10-00300	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edward Roland I		ips, III 1-For State	St	ate of	Maryla		-	tment of			d Mei	ntal Hy	_	n N		0	363	04
Physicia	an/	Registrar 1. Decedent's Name	e (First, Midd	e,Last)									2. Date of De Month October				3. Time of Death	
Medical Exami	ner	Foward R 4a. Facility Name (i	oland 1	hilli	ps, II	I mber)			1h City	, Town, or L	ocation	of Death	October		010 4c. County of	Death	1002 1113	
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Funeral		5. Social Security N 212-64-258		6. Sex		7. Age (In y	ge (In yrs. last birthday) If Under 1 Year If Under 2 ² Months Days Hours					1	•		9. Birtl	nplace (State or F	oreign	
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any	ŀ	Usual Residence of 10a. State	10b. County			10c. (City, T	own or Locati	ion								10d. Inside City L	imits
		MD	Mor	tgome	erv		Ker	sington									1 Yes 2	No
larylar 28a-f s at on	Director	10e. Street and Nur						3	10f. Z	ip Code			1	10g. C	itizen of Wha	at Coun	ry?	
the M	قَ	4110 Spru	ell Dri	re	20895							USA						
h with	eral	11. Marital Status 1 X Never Marrie	nd 2	12 arried	2. Was Dece Armed Fo		in U.S			dent of Hisp cify Cuban,			cify Yes or N	lo-	14. Race - White,		an Indian, Black,	
5-0036 led within 72 hours after death with the Maryland Hygiene to ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Funeral	3 Widowed		1	Yes es, Give Year	2 🗶 N	No			2X No			,		Specify: V	hite		
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212 ould be I Ment mark		19a. Informant's Na	me/Relations	nip (Type	, Print)			19b. Mailing	Addres	ss (Street	and Nu	ımber or Ru	ıral Route N	umber,	City or Town	, State,	Zip Code)	
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nore, ages l ar nt of Hea nt: If ite		20a. Method of Disp 1 Burial 2	cosition Cremation	3	Removal fro	m State	cre	ace of Dispos ematory or oth	ner plac	e)	•	No	Date	200	. Location -	City or	own, State	
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Baltin permit. Departm Importa injury o		1/mL	9	1	1			Fra	ncis	J. Co.	llins	Funer	al Home	Inc Spr	ing, M	209	001	
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/Medical examiner		Immediate Cause (I	- Final disease	a. Hy	pertensiv			rotic Cardi	ovasc	ular Disc	ease	Met	hadone	in	toxica	tio	n Death	
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Box 6876(e death certificate the attending physed for use as the b	Physician/M	1 Yes 2 N		nown d	Pregna	ant at time o	of deat	th 5 Oth	ner (Sp	ecify)								
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88		- 4	1/	//						O.C.M	1.E.				tober 31,			
	ŀ	30. Name and addre	1 /	who com	pleted cause	e of death ((Item 2	-										
OCME		Mary G. Rip	-	Deput	y Chief M					Street,	Baltin	nore, MI	21201					
St Regist	ate rar	31. Date filed (Mant	p. Day Year)	2010		gistrar's Sig	inatur	par	d.	4.								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Carolyn Hearthway Quillin 1125 PM 2010 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury ogsta Hospice att comico 7. Age (In yrs. last birthday) 101 v... If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral Months MD^{untry)} 220-32-1419 1 □ M 2 🗓 F Hours /4°7"129"0"9" Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21842 10308 Golf Course Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White d Mental Hygiene. marked other than "natural", 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Hitchens Hearthway Walter Hearthway Page 1 and 2 should of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 High Brook Dr., Richardson, TX 75080 Lisa Bassett/Granddaughter Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/2010 Buckingham Cem. Berlin, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home William St., Berlin, MD 21811 108 23a. Part 1. Entering disease for complications the gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ars Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and ibe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 42 hours affard death. To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗷 No 1 🗌 Yes Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29505 10-31-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DH 6 GREGORIO M. 5302 CHINABERRY DR. SALISBURY MD 21801 050

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robinson William 2.35 PM 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MARY S Veterans charlotte Hall CHARLOTTE Home HALL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🕅 M 2 🗆 F 218-28-167 20 Director MAIZHIA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director Waldort 1 Yes 2 No Charles MAZYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral PI USA Leland 20601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

✓ Yes 2

No Black, White, etc. ğ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Supervisor 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robin elix 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 120 Henderson S.W 22180 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State MI Manyland -12-10 4 Donation 5 Other (Specify) Tugsco Rd. any inj 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician, RDS15 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner lett toot gangrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner signed by the attending physician and deetached for use as the burial-transit Puipheral arterial Sevene that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Diabetes IF FEMALE: NA yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Hypertensian 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Charonic autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 2 🗹 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

 Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 completed filled in by the

Baltimore, Maryland 21215-0036

BBBH

To the within 2 To the F

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 hobor OS

Santha

NOV 0 4

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

, 100 Hospital Rd,

Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the fline, date and place, and due to the cause(s) and manner as stated.

D0064324

29c. License number

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

11/1/2010

City or Town, State)

Paince Frederick, mo, 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36307 State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1340 M Leslie Hayes Russo 2016 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Niconico SAUSBUR 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days Min. (Month, Day, 55 008-46-3213 Director <u>01/20/1955</u> Washington, DC Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Wicomico Salisbury ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 506 Indian lane 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. attorney 5+ is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas L. Hayes Jennie Christy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 506 Indian Lane, Salisbury, Christopher Russo/spouse MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Salisbury Crematory 11/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD of Funeral Service HOITOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Onset and Death Physician/ astal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the sand should be detached 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Was autopsy performed?

Yes 2 No page 2 prior to completion of cause of death? certificate has 2. No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 X No 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after death. I Director: After t Certificate: 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 32. Registrar's Signature, State Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36308 State of Maryland / Department of Health and Mental Hygien 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARJORIE B. \mathbf{a}^{M} RODKEY NOVEMBER 14. 2010 4:05 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Heron Point - Talbot Wing Chestertown Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 □ M 2012 F Sept 12, 91 1919 Washington 519-05-0908 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1√2 Yes 2 □ No Kent Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2025 Heron Point 21620 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Media Aide 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray Lewis Boughton Cora Eleanor White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Rodkey (son) 3921 Dark Hollow Rd. Medford, OR. 97501 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Kent Cremation Service 11/15/10 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lo 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carise (Final EREBROVASCULAR month disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Vear 5 Other (specify) underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Mo 24a. Was an autopsy 1 ☐ Yes 2 ☐ No lace of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examirer must be notified at

d 2 should be filed within 72 hours after death with 1 th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or ? traumatic event, the Medical Examiner must be on

Pages 1 and 2 s ment of Health ar

27 If Item 2

Department of Important; If any injury or once, once,

Baltimore, Maryland 21215-0036

the

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

MD

the death certificate be executed burial-tra physician the use as ρ signed to page 2 certificate Physician: director, this After or Attending

after death. by filled in

within 24 hours a

completely

Division of Vital Records, P.O. Box 68760,

1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	-
art II. Other significant conditions of	ontributing to death but not resulting in th	16
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DEMENTIA	·	

WRUNARY	ANTITOU	DISERSE	-
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DEMENTIA			
Was case referred to medical			
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examiner? 1 ☐ Yes 2 🛣 No	Hospi	tal: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3				g Home 5 ☐ Residence 6 ☐ Other (Specify)				
Z LI Accident	nding estigation	8a. Date of Injury (Month, Day, Year)	28b. Time of Injury		c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred				
	uld not be ermined 28	8e. Place of Injury - At hos building, etc. <i>(Specify</i>	me, farm, street, fa	actory, o	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a Certifier 1 Certi	fylna Physicia	n. To the hest of my know	vledge death occ	urred at	the time. d	ate and place	and due to the cause(s) and manner as stated.				

2010

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death oc and manner on the basis of examination and/or invest and manner stated.	curred at the time, date and place, and due to t igation, in my opinion, death occurred at the tim	he cause(s) and manner as stated. he, date and place, and due to the cause(s)
29b. Signature and title of certifier Hu H M W W	29c. License number D 0041587	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner harles Medical Center 0 IVISTA Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min AUG. 7, 1922 MARYLAND 215-18-0595 88 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Ħ 10c. City. Town or Location Director Examiner must be notified 1 Yes 2 No MD CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral UNITED STATES 5365 MASON SPRINGS ROAD 20640 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 1. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. ò ò 1 Never Married 2 Married 3altimore, Maryland 27215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: BLACK "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 tand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) EXPLOSIVE WORKER FEDERAL GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည GEORGE L. SMITH PEARL BUTLER SMITH imith, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CELESTINE SMITH/WIFE 5365 MASON SPRINGS ROAD, INDIAN HEAD, MARYLAND 20640 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. ST. CHARLES CEMETERY NOV. 6, 2010 GLYMONT, MARYLAND THORNTON FINERAL HOME, PA 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 21. Six ture of Funeral Arvice Live see 12/DIA C. THORNION JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATTWO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? Yes 2 No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 100 ည Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 \square Pending work: 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

BBS

address of pe

31. Date filed (Mopth, Day, Year)

ause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EVEN 1000 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Tate House Hospice Anne Arundel Linthicum 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 9<u>69</u> Months Days Hours Min. 578-88-1178 41 Yrs. Sept. Director DC Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Fort Washington Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 9203 Branchview Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: "natural", 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aid Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ൧ Jean Laura Summers unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9203 Branchview Drive Fort Washington, Md. 20744 Clarice E. Dougal - Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place Morris Baptist Church Cemetery 1 Burial 2 Cremation 3 Removal from State Mt. November 5, 4 \square Donation 5 \square Other (Specify) Hume, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ OF disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day Yes 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by I BROMA TOSIS 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown has been signed by Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 death? within 24 hours after death.

To the Funeral Director: After this certificate heompleted filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 o Other: 4 Nursing Home 5 Residence 6 Other (Specify) TATE 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of HOUSE Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ CHARLES MONTAGUE SADELL OCT P Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL BETHESDA 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 1 🕱 M 2 🗆 F Months Days Hours Min Missouri 34 486-06-3503 1976 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 ☐ No Missouri Platte Weston 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? Funeral items 23a USA 621 Springs Annex St. 64098 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu onee. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian rmed Forces?

XYes 2 \(\sum \) No 1995 Black, White, etc. 1 Never Married 2 Married δ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 2010 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) US Army Soldier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles W. Sadell Donnalyn Jane Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Springs Annex St. Weston, MO 64098 Kristin Dawn Sadell/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/10 Central States Crematory Riverside, MO 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Murphy FH 4510 Wilson Blvd Arlington, VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Complications disease or condition Medical resulting in death) or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav 5 Other (specify) Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an sate has bage 2 s autopsy performed? prior to completion of cause of death? his certificate hil director, page 1

Yes 2 □ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Karatient 2 ER/Outpatient 3 DOA 1 X Yes 2 □ No မ 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending TED BLAST 1 Yes 2 🗌 No 2:55 P M Investigation Accident OCT 5 2010 after death in 24 hous. the Funeral Directory of filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ARIF KALA 4 Homicide determined BATTLEFIELD AFGHANISTAN Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number COIL NO. GIN 0101242667 OCT 25 2010 (VA) ARMED FORCES INSTITUTE OF PATHOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ROBERT

C

31. Date filed (Month, Day, Year)
NOV 0 5 2010

STABLEY

MC

32. Registrar's Sign

CDR

1413 RESEARCH BLVD., ROCKVILLE MD 20850

			Amend 10a-f, pe	se Type or	Print in I	Black Ir	ndelib artmer	le Ink	c. Ens	ure A	II Copie	s Are	Legible	e.		
			For State Registrar	Otato c	i wa ya		tificat					Reg. No		36312		
	Discolate		1. Decedent's Name (First, Middle,	Last)							2. Date of De	eath		3. Time of Death		
	Physicia Medio		4	ienko		HOVEN							BER 2 ZOIO 12:10 PM			
	Examin		4a. Facility Name (if not institution, s	ity Hospi	Ltal		anhar				Pi	County of De	Se orges			
	Funeral Director		300 03 0040	6. Sex 1 ፟ M 2 □ F	7. Age (In yrs. la 97	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi		3 Pé	Birthplace (State or Foreign County) NISYLVania		
	ıryland a-f show ied at	ctor	Usual Residence of Decedent 10a State 10b. County	Соомоля		y, Jown or Lo Lake anham	cation Como							10d. Inside City Limits		
	th the Ma 3a or 28a t be notif	al Dire	Maryland Prince 10e PoetBoxum274 Com 6503 Westview La	o Road		ici i i ici i	10f. Zip	Code	1843	37		_	10g. Citizen of What Country? U.S.A.			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Dece	e 1022		Was Deced f Yes, spec				cify Yes or No Rican, etc.)		14. Race - Ar Black, Wh	nerican Indian, nite, etc. White		
21215-0036	72 hour in "natur Medical	mplete	15. Decedent (Specify only highes	d's Education t grade completed)		16a. Deced (Give	dent's Usua kind of wor O NOT use	rk done d		t of worki	ng	16b. K	(ind of Busines	ss Industry		
	within giene. Jer tha t, the		Elementary/Seconday (0-12)	4 College (1	-4 or 5+)	Lumk	ema	n '				Se	lf Empl	oyed		
Maryland	d be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middle, La Joseph A Sienko						(First, Middle ahalsk		Surname)					
	d 2 shoul salth and I n 27 is m er traums		19a. Informant's Name/Relationshi Juanita McCall	19b. Mailir 6503	g Address West	(Street a	nd Numbe Lan e	er or Rura La	nham, l	er, City or MD 20	70wn, State, . 0706	Zip Code)				
Baltimore,	Page 1 ar nent of He int: If iten iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		State C	Place of Disponentery, cremetery,	natory or o	ther plac) _{ate}		. Location - City or Town, State ncock, New York			
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	Examiner	ı.	Due to (or as a consequence of):													
6	executed an and ial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	c	netas	tatic	. 0	dise	as e	2						
09		_														
. Box 68760	ath certifi attending for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 🗆 Live	come of pregna Birth 2 Feta nant at time of c	al death 3 🛚	Ectopic Other (sp		у				23d. Date of o	delivery Day Year		
P.0	es that the de signed by the be detached		Part II, Other significant condition			ulting in the ι	nderlying (cause giv	en in Part	l.				to the cause of death?		
rds,	requires been sig should b	ted	- Diasete	es usell	Ce pus						1 🗆	Yes 2		Probably 4 Unknown		
e O O	law re has be ge 2 sh	Completed by	- 1+y per	tensia	M						24a. Was auto perf		24b. Were a prior t death	autopsy findings available o completion of cause of ?		
Ä	sician: The la certificate ha rector, page		25. Was case referred to medical	m, a				26 PIs	ace of Dea	th (Chack	1 Tes	2 N	0 1 🗆 1	/es 2 □ No		
Vita	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outpatier	nt 3 🗆 D0	Othe	r			idence 6	6 ☐ Other (Sp	ecify)		
of	ding Phy th. After this funeral of		27. Manner of Death 1. Natural 5 □ Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	2	8c. Injury	at		28d. Describe					
Division of Vital Records,	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	of Injury - At ho		M eet, factory	1 🗆	Yes 2		28f. Location (Rural Route Number,		
۵	Hospital 4 hours a funeral Died i	Medical C		Physician: To the base										stated. e cause(s) and manner stated.		
	To the I within 2 To the I complet	Me		Nurse Practioner:			death occu		time, date			ne cause(s) and manner	as stated.		
	≓ ≥ ¥ 8			Mem	1				59	09			te signed (Moi			
? N	2 10		30. Name and address of person w	ho completed caus	se of death (Item	1 23a) (Type, F	Print)				anh	Oem	mD	. 20706		
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 4 2010	Server 32. R	egistraris Signat	Sail)					/				

10-08460 Lelia Savoy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2010 1056 hrs SAVOY **Medical Examiner** LELIA 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Co Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country)
WASHINGTON, DC Months Days Hours Director MARCH 27 1946 1 ___M 2 X F Yrs 64 578-58-6370 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 X Yes 2 No PRINCE GEORGE'S LANHAM 132 (hours after death with the Maryland MD Directo 10g, Citizen of What Country 10e, Street and Number 10f. Zip Code r items 23a or 28 nust be notified USA 20706 9931 GREEN BELT ROAD T-3 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 9 BLACK 1 Yes 2 X No specify: Specify: 3 X Widowed 4 Divorced If Yes, Give Year Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 GOVERNMENT ACCOUNTANT 12TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FREDDIE BELL JONES Be UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 9931 GREEN BELT RD. T-3 LANHAM, MARYLAND 20706 CHRISTINA CLARK/DGT. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/17/2010 CHELTENHAM, MARYLAND MD VETERANS CEMETERY ortant: Department 4 Donation 5 Other Specify: Signature of Puneral 22. Name and Address of Facility B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -X UNPENDED ^MES ም. 27, per ME g910 12/7/10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death 2 past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown n signed by the a d be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? page ✓ Yes 2 No ✓ Yes 2 No certificate this certifical director, 1 26.Place of Death (Check only one) 25. Was case referred to medical æ examiner? Other Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 Yes ို No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury After Manner of Death 1 Natural 1 Yes 2 No Pending tþe 2 ___ Accident Investigation in by 1 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Suicide Could not be or Town, State) determined fo the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 6, 2010 tellan O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 32. Registrar's Signatul 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<u>6 2010</u> KIMBERLY SUTTON OCTOBER 3:02 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10809 WEST WOODS DRIVE CHELTENHAM PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Min NOV 4 1 - M 2 - XF MARYLAND 218-02-7213 40 1969 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Me A al Examiner must be notified at Director 1 X Yes 2 No MD PRINCE GEORGE'S CHELTENHAM 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 10809 WEST WOODS DRIVE 20623 IISA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event; the Me. Elementary/Seconday (0-12) 12TH College (1-4 or 5+) DENTAL TECH. PRIVATE æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OMAR E. SMITH SHIRLEAN TOLSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT SUTTON/HUSBAND 10809 WEST WOODS DRIVE CHELTENHAM, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from MD VETERANS CEMETERY 11/4/2010 4 Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner LUNG METASTASIS Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of and -transit Exami The law requires that the death certificate be executed OVARIAN METASTASIS that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 No Yes 2 X No 1 Yes of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 **X**No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 Pending work? Division 2 🗌 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral Completed filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nur e Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 27, 2010 D43162 completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

MELVIN GASKNYS

31. Date filed (Month, Day, Year) NOV 0 4 2010

M.D.

32. Registrar's Signature

7831 BELLEPOINT DRIVE GREENBELT, MARYLAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 7:15 PM Betty Irene Sherrod October 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery . Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 🗆 M 2 🔀 F Days Hours Director 579-30-3040 84 Feb Usual Residence of Decedent 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George's Greenbelt 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Ridge Road 20770 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Litton Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Boyer Noreen Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodrow Sherrod - Son P.O. Box 9592 Baltimore, MD 21237 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Ft. Lincoln Crematory 11/5/10 4 ☐ Donation 5 ☐ Other (Specify) Brentwood 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Taxes 3401 Bladensburg Rd. Brentwood, MD 23a. Part 1, Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failurg. List only one cause on each line Immediate Cause (Final Onset and Death h sician/ disease or condition resulting in death) Medical Due to (or as a consequence off Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Pregnant at time of death Dav Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ropath 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Suursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of De th Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29c. License number
0 0 0 5 0 6 / 2

State Registrar 9701 Velrs Drive Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. MALLER

AMUEL

31. Date filed (Month, Day, Year)

mp

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31 <u>2010</u> Physician/ OCTOBER SAUNDERS 7:15 P M Ρ. OTTS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 6717 SEAT PLEASANT DRIVE CAPITOL HEIGHTS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 🖾 M 2 🗆 I Hours APRIL IO VIRGINIA ''1937 73 **Director** 577-52-0860 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural". or frame 200. 10d. Inside City Limits 10a. State 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20743 6717 SEAT PLEASANT DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 BLACK 1 Yes 2 No If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 12TH BUS DRIVER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MATTIE PAYNE JOHN SAUNDERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6717 SEAT PLEASANT DRIVE CAPITOL HEIGHTS, MARYLAND LOUISE SAUNDERS/WIFE Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place HARMONY CEMETERY 11/5/2010 LANDOVER, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea Immediate Cause (Final Physician HYPERTENSION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner END STAGE KIDNEY DISEASE Sequentially list conditions, Examine if any, teauling to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or se a nonsequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The there is the certificate has been signed by the attending physician and the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the Iunnaral director, page 2 should be detached for use as the burial-transit DIABETES MELLITUS that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🎦 No **Division of Vital** Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2X No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

NDA U

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sign

D58182

DONALD GEORGE M.D. 7500 GREENWAY CENTER DRIVE #113 GREENBELT, MARYLAND 20770

NOVEMBER 3, 2010

Please Type or Print in Black Indelible Ink Frsure All Copies Are Legitle dk Amend 15, 16a & 19b per File 23a le Frsure All Copies Are Legitle dk State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician/ Everson Richard Sherwood 2010 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 916 Shallmar Road Garrett Kitzmiller If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Min. Hours 1 X M 2 🗆 F 218-18-4428 Director 86 1924 WV Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Garrett Kitzmiller 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe 23a or Funeral 916 Shallmar Road 21538 USA items ? death \ 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1944-1946 Black, White, etc. by 1 Never Married 2 Married ō hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance- Operator Railroad 8 -12is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ഉ Richard Sherwood Clementine Paugh 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1052
196 Shallmar Road, Kitzmiller, MD 21538 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Deborah James-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/8/2010 Elk Garden, WV Kalbaugh Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 2nd St. Oakland, MD 21550 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic-squemous-cell-cancer-of-ite - mate t lass Medical Due to (or as a consequence of) Examiner Metastatic squamous cell cancer of lip 14 months Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ending physician a use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ę Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached a
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 To Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Il or Attending Physician: The law I after death. Director: After this certificate has b Coronary disease autopsy performed? Chronic obstructive pulmonary disease 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 11/4/2010 D47925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 311 North 4th Street, Oakland, MD 21550 Charles Walch, M.D. 31. Date filed (Month, Day, Year) 37. Registrar's Signature State NOV - 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 5:40AM Ralph Merrill Simpson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegany Cumberland Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year)

March 16, 1925 1 M 2 D F Min 218-16-3954 **Director** 85 Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗷 No Maryland Allegany Midland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 19501 Old Dan's Rock Road, S.W. 21542 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☑ No Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Welder Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Harry Simpson Lavina Machin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Laurelwood Drive, Lonaconing, Maryland, 21539 Gary Simpson - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 3 Sunset Memorial Park 2010 Cumberland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. madle 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 AND 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1-Natural injury work? 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UDITER

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Divommu.MD 12500 Dulowbrook Road Cumborland, Many Knol 21802 32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** IQL 1000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 06/12/1975 35 Director 557-51-2794 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at tX Yes 2 □ No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Numbe 10f, Zip-Code USA 20878 458 Lady Fern Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Corporate Executive College (1-4 or 5+) Elementary/Secondary (0-12) Board 5+ Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injuy or other traumatic event one. Be Dana Rosen Lawrence Greatman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 458 Lady Fern Place, Gaithersburg, Maryland 20878 Jeffrey Swers, husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Garden of Remembrance Memorial Park 1 Burial 2 Cremation 3 Removal from State Clarksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION,
1091 Rockville Pike, Rockville, 21. Signature of Funeral Service Licensee MO1255 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diomi **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or, The law requires that the death certificate be executed attending physician and do for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☑ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ✓ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) te has been signed by the al page 2 should be detached t P.O. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 🗌 No 2 🗌 No Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner's Hospital: 1 / Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 🗆 DOA မ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural Injury 5 Pending 1 Yes 2 No after death. Director; Aft investigation Accident filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the è

> State Registrar

one)

title of certifier

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NOA

29b. Signat

and address of person who completed cause of death (Item 23a) (Type, Print) TMAN 31. Date filed (Month, Day, Year)

29c. License number

DOD 541

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2010 8:08 Rhonda Ann Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 8. Date of Birth
(Month, Day, Year)
July 9, 1958 9. Birthplace (State or Foreign Country)
Washington, DC Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. . Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F Months 577-80-4988 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Maryland Prince George's District Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3134 Dynasty Drive 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Law Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Smith, Jr. Rhoda Ann Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rhoda A. Smith/mother 3134 Dynasty Drive District Heights, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/2/2010 Woodbine, Maryland 21. Sig a ure of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 MD 21029 sanuta 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEUMON Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury UNG that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery ☐ Live Birth 2 ∟ Fe≀ar uea. ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 1 completed filled in by the funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

recen

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene												
		-	For State Registrar	Certificate of Death						Reg. No. 2010 36321		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) ELEANOR KAE SPENCER 2. Date of De Month						Day Year 1075			
	Examin		4a. Facility Name (if not institution, give street and number) Memorial Hospit			4b. City, Town, or Location of Death EASTON			eath	4c. County of Death		
	Funeral Director	,	5. Social Security Number 222–36–5024	(In yrs. last birthday) If Under 1 Year I If Under 24 Hrs.								
	nd show at	1.1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location							10d. Inside City Limits	
	e filed within 72 hours after death with the Maryland tal Hygiene. An other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MD TAI	ST. MICHAELS							1 X Yes 2 □ No	
		Funeral D	10e. Street and Number 24700 DEEP WATER POINT DRIVE, UNIT 11 21663 10g. Citizen of What Country? USA							ntry?		
9036		ğ	11. Marital Status 1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	iver in U.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:				? (Specify Yes or No- uerto Rican, etc.)	No-) 14. Race - American Indian, Black, White, etc. Specify: WHITE			
21215-0036	72 hou n "natu fedical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)						working	16b. Kind of Business Industry SHORE HEALTH SYSTEM		
212	permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce.	To Be Cor	Elementary/Seconday (0-12) College (1-4 or 5+)			ACCOUNTANT				FINANCIAL DEPARTMENT		
and			17. Father's Name (First, Middle, Last) SIDNEY WILSON 18. Mother's Name (First, Middle JOANNE TJERNLU									
altimore, Maryland			19a. Informant's Name/Relations WILLIAM HUGH		SAND	19b. Mailing 2470	Address (Stre	et and Number o WATER P	r Rural Route Numbe	r, CiST Town	TCHAE	LS, MD 21663
			20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (cem	etery, crema	ition (Name of atory or other p	lace) ATION 10	Date /31/2010	20c. Locatio	-	own, State
Balt			21. Signature of Funeral Service	MERCERO	5	ा प्रस	PWO I T	ress of Facility HELFENB	EIN & NEW	NAM FUN	ERAL	номе, Р.А. 21601
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onstand Death Instituted Cause (Final disease or condition resulting in death) Bue to (or as a consequence of): Due to (or as a consequence of):									
			IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 3 Ectopic pregnancy 5 Other (specify) 5 Unknown 5 Other (specify) 5 O								23d. Date of delivery Month Day Year	
s, P.O.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death									
on of Vital Records,		To B	Respiratory Failure 1 Yes 2 No 3 Probably 4 Unkarrent United States 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unkarrent United States 24b. Were autopsy findings avail prior to completion of cause death? 1 Yes 2 No 1 Yes 2 No							ompletion of cause of		
			25. Was case referred to medical examiner?									
			27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of inju	(Month, Day, Year) injury work? 1 Yes 2 No 1 No 286 Place of Injury - 4t home farm street factory office.					e how injury occurred		
Division		Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e. Place of Inj						Street and Number or Rural Route Number, wn, State)		
_		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 28 2010									
J	<i>-</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 509 Idlewid Avenue Stell Nam Si De Shields MD Egston, MD 21/00!									
	Sta Registra		31. Date filed (Month Day, Year)	0 1 2010 D	r's Signature	Å	bark		, n/1)	1 100	<i>_</i>	
			INUV	U VIO	10000	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PATRICIA MARIE SHERIDAN 1022 AM october 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Easton The memorial ialbot If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 215-58-8533 1 M 2 K F Month Day 7 59 Director MARYLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD TALBOT. EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11652 WYE HEIGHTS ROAD 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) HOME INTERIOR Elementary/Seconday (0-12) College (1-4 or 5+) STORE MANAGER DECORATING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ൧ **BRIAN SHERIDAN** AILEEN WATSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KARA SHERIDAN, SISTER 122 CASTLE HEIGHTS AVENUE, NYACK, NY 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 10/31/2010 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MP 21601 EROL MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) ☐ Pregnam ☐ Unknown signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 🛂 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has funeral director, page 2: autopsy performed Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} Hospital: 2 🗹 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) Multituse D0059487 10-29-2010

State Registrar

DHMH 17 Rev 7/2009

219 SOUTH WASHINGTON STREET, EASTON, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN BOTSIS

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Nationa

32. Registrar's Signature

A REAL PROPERTY

hanna

31. Date filed (Month, Pay, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🚄 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month way 11 Physician/ Adeline Burroughs Shrewsbury 3.45 A.M 7010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2XX Months Hours Min 217-60-9266 97 Director Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2xxNo MD Anne Arundel Gambrills 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21054 USA 915 St. Michael Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. o ⋧ 1 Never Married 2 Married Yes 2x X No Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2xx No Specify: White "natural", Specify: 3¥XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of Percival Burroughs Adeline Claggett Wood permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Shrewsbury 915 St. Michael Dr. Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/13/2010 Atlantic Crematory Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, 851 Annapolis RD. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner enno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and I-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician of for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day certificate has been signed by the rirector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 🗌 Yes ☐ Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) 2 No ျပ Other: 1 🗌 Yeş 1 Npatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natural 5 Pending work 24 hours after death. Funeral Director: A 1 🔲 Yes 2 🗌 No 2 Accident 3 Suicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Da State Registrar

SHOEWS BURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nicolena Smith 8:15 A M November 15, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Country Meadows of Frederick Frederick Frederick If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8, Date of Birth **Funeral** 1 🗆 M 2 🔀 F Days Months Hours Min 214-10-4772 91 **Director** September 14, 1919 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5955 Quinn Orchard Road, Room 145 21704 United States of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced Specify: Completed White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Carmelo Marrone Irene Pacino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Wallace / Daughter 6613 Jacks Court, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery 20a, Method of Disposition 20c. Location - City or Town, State November 20. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Keeney & Bastord P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 Signature of Furneral S M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a d be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 21 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 🗌 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Fercil Other: 4 Nursing Home 1 🗌 Yes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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31. Date filed (Month, Day, Year)

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32. Reg

Thomas

strar's Signature

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Frederica MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 010 36326 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 1, 2010 Kevin Vincent Thomas Medical Examiner 0010 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Country) Months Days Director 216-35-0319 1 XM 2 F 18 02/22/1992 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show Maryland Baltimore hours after death with the Maryland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1710 Montray Street 21230 USA 238 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes 4 Divorced Yes 2 X No specify: Widowed f Yes, Give Year Specify. White þ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 timore, MD 21215-0036 7th Carpenter Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson Richard Thomas, Jr. Helen I. Dunnigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson R. Thomas, Jr. 1706 Montray Street, Baltimore, MD 21230 (Father) of Health au
If item 27
ther traums 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/8/2010 Baltimore, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Phillip A. Weatherford F.S. P.A. Signature of Funeral Service Licensee 2431 E. Oliver STreet, Baltimore MD 21213 23a, Part I. Enter the d sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed andtran sician/Medical UNPENDED **AMENDED** attending physician or use as the burial Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. <u>6</u> 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed death? Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury Passenger in motor vehicle collision **FOUND** Natural 5 Pending 1 Yes 2 ✔ No Director: I in by the f Oct 31, 2010 2333 hrs 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1200 Block of S. Hanover Street, Baltimore, MD determined (Specify) Local Street Homicide 29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E November 1, 2010 Pl 1 cht 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD **Assistant Medical Examiner** 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State <u>NOV O 5 2010</u> Registrar

DHMH 17 Rev 1/2001 OCME 2006

		Please	Type or Print in					_	jible.		
		State of Maryland / Department of Health and N State Certificate of Death				Mental Hygiene Reg. No. 2010 36327					
		Decedent's Name (First, Middle, La.	st)				2. Date of De	eath	Voor	3. Time of D	
Physic /Med		MARY ELIZABETH THOMAS					October 31, 2010 4:30 A M				А м
Exam	iner	, ,	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3851 Walt Thomas Road Crisfield				1		ty of Death Omerse	t.	
Funera	1	Social Security Number 6. S	ex 7. Age (In yr	s. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth		ace (State or	Foreign
Directo	r	217–44–1805 ¹ Usual Residence of Decedent						Mary.			
ryland	_	10a. State 10b. County		City, Town o					10	d. Inside City	
he Ma 28a-f s	Director	Maryland Somers 10e. Street and Number	et		risfield			40 0"		1 ☐ Yes 2	2 🔀 No
3a or	JE Dir	0057 7	Road		10f. Zip Code	21817		10g. Citizen o	.S.A.	ry?	
r deatl	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Ye's or No o Rican, etc.)	o- 14. R	ace - America lack, White, e		
If e, INIAl yially ZIZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, IT Medical Examinations to only that the most continued to the continued	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:		1 □Yes 2X No		,		ity: Whi		
72 hou	eted	15. Decedent's Ed	lucation	16a. D	ecedent's Usual Occu	pation	kina	16b. Kind of	Business/Ind	ustry	
within within and the within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done ife. DO NOT use retire None	daning most of wor	ning		None		
filed vill Hygie other vent, II	Be Co	17. Father's Name (First, Middle, Last,			NONC	18. Mother's Nan	ne (First, Middle				
yidi buld be Menta arked atic ev	To E	R. Walton Thomas			Ida Marie Chris						
Midel d 2 sho d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (R. Walton Thomas	,,		Mailing Address <i>(Str</i> ee 51 Walt Th					Code) 817	
s 1 and 1 Heal		20a. Method of Disposition	20b		isposition (Name of crematory or other pla		Date		n - City or To		
rmit. Pages spartment of I portant: If its py injury or of I po		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	nemoval from State		ls Cemeter	1 37 //	1/2010	Marion	n Stat	ion, M	D
parimition by Michael 2 permit. Pages 1 and 2 pepariment of Health a Important: If item 27 is any injury or other trained.		21. Signature of Funeral Service Her			22. Name and Addr Bradshaw	& Sons Fu					
		Robert H. Brads 23a. Part 1. Enter the disease, or com	plications that caused the de	ath. Do no	306 W. Ma t enter the mode of dy				2181	Approximate	
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CHRONIC TOWNS ISSUED Interval Between Onset and Death Status Sta									
/Medical		resulting in death)	Due to (or as a conse	equence of)	:						
D ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of)							
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c									
te be ex ysician a e burial		d									
entificate ling phys	Physician/Medical	IF FEMALE:									
eath ce attendii	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death	3 Ectopic pregnan 5 Other (specify)	су			Date of delive Month	,	ear
at the d by the tached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown		o Li Other (speeny)						
ires the	2	Part II. Other significant conditions of	ontributing to death but not re	esulting in th	ne underlying cause gi	ven in Part I.		tobacco use co			
w requires been signatured by	letec						24a. Was			osy findings a	
The la ate has page 2	Completed						auto perf		prior to cor death?	npletion of ca	use of
VITA iclan: certific ector,	Be (25. Was case referred to medical examiner?	Hospital:			26. Place of Dea					
g Phys er this eral dir	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Tin	ne of 28c. Inju			how injury occ		/)	
ending sath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation		Inju		rk?]Yes 2∐No					
or Att after d Direct in by	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm cify)	, street, factory, office		28f. Location City or To	(Street and Nur own, State)	mber or Rura	l Route Numb	er,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the t		29a. Certifier 1 Certifying Ph	ysician: To the best of my k niner: On the basis of exami	nowledge,	death occurred at the	time, date and place	e, and due to th	e cause(s) and	manner as s	tated.	
the H thin 24 the F	Medical	one) 29b. Signature and title of certifier	and manner stated.	ination and		se number	irred at the time	29d. Date sig			
5 ≥ 5 S		250. Olgitatore and title of certifier	e no		D-398			Novemb			
4CY		30. Name and address of person who	completed cause of death (It	em 23a) (Ty	/pe, Print)						
9	tate	M. Atkins, M.D 31. Date filed (Month, Day, Year)	201 Hall Hic	hway	- Crisfiel	d, MD 2]	1817				
Regis		NOV 01	2010 32. Registrar's Sig	, B.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician/ Day 22 1516 B.T. Truxon 2010 Medical Thurman 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center Baltimore University Baltimore County If Under 1 Year If Under 24 His 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Hours Min. Months 218-34-864 73 Director 10-02 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. Count 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md Hnnes 10e. Street and Number 10g. Citizen of What Country? Funeral 1638 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces'
1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married 2 | No Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed Black of Health and Mental Hygiene.
item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ bert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Bornation 5 ☐ Other (Specify) cemetery, crematory or other place) ò remutory LLC 10-29-2010 injury DOVER 22. Name and Albress of Facility Bennie Smith F uneral Service License Signature any eral Home Divison St., Dover, Delaware 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Septicamia Medical resulting in death) Due to (or as a consequence of): Examiner enterecocord becteremin Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Oscidomonal Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Telan Carlo 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 L 9 Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 🛣 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 🔀 No Other: Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No **Natural** 5 Pending injury Investigation 6 Could not be Accident filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 1942468384 10/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Entaw Street Bultimore, MD 2/211 34VA 6. Hwan of 31. Date filed (Morlth, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 26, 2010 Frank J. Ustaszewski 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Golden LivingCenter Nursing Home Frederick Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔯 M 2 🗆 F Months Hours Min. Jan. 3 Mary Tand 1920 90 Director 213-18-7355 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits the Maryland Director items 23a or 28a-f s ner must be notified Frederick Frederick Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hyglene.
and: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must buy or 21701 United States 30 North Place 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give WWTTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Year or Dates. WWII Specify: White 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (11,115) မ Joseph Ustaszewski Veliera Jakubiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Walsh / Great-Niece 628 Morgana Drive, Shepherdstown, WV 25443 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I limportant: If ite any injury or of October 30. Rest haven 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 2010 Frederick, Maryland 21. Signature Resthaven Funeral Services, Skkot Cody MD 21701 9501 Catoctin Mountain Hwy. Frederick, And 1. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demention Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Exami Cause (Disease or in that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 9 Unknown certificate has been signed by the irector, page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? e Funeral Director: After death. М 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

2 tIUA State

within 24 ho

To the Fune

completed fi

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

29b. Signature

(Check

only ope

31. Date filed (Month, Day, Yea

title of certifie

Praveen Bolarum, M.D.

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2010

32. Regist ar's Signature

Charres

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

rance

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOO62123.

29d. Date signed (Month, Day, Year)

October 28, 2010

License number

196 Thomas Johnson Drive, Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Kenneth C. Wray, Sr. 2010 November 2:43a. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 14, **Funeral** 9. Birthplace (State or Foreign Days 85 Hours 365-20-1159 Michigan Director 1925 Usual Residence of Decedent 28a-f shov 10a. State 10b County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2452 Bear Den Road 21701 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1X Yes 2 \(\square\) No \(1944\) Black, White, etc. 1 Never Married 2XX Married δ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates white 3 Widowed 4 Divorced 1975 Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Memorex Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ Roscoe James Wray Elizabeth Barnard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Paula Wray - wife 2452 Bear Den Road, Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 11/05/2010 Stauffer Crematory Frederick, Maryland 4 Depnation 5 Other (Specify) 22. Name and Address of Facility ture of Funeral Service Licenses Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Fi boosi disease or condition resulting in death) monary Medical Die to (or as a consequence Examiner hysem a Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burlal-t physician sthe burlal Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation Atrial 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performe certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital HUSPILE HOUSE ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah Hemen 5 1/10 mas Uhnson DV Frederick MD 2170) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 O Q Di D 8:24A Thomas Edward Whitman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** oastal Hospice Wi at The Lak COMICO lisbur If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 🕱 M 2 🗆 F Months Days Hours Min. 1/12/1928 213-22-9892 Director 82 Usual Residence of Decedent 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me I.cal Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Talbot St. Michaels 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21663 23650 Mt. Pleasant Landing 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 St No Specify: Completed 3 Widowed M Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hobby Horse retail sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Norman Edward Whitman Evelyn Hope Phipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2166323650 Mt. Pleasant Landing St. Michaels MD Deborah Candice Kastel (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/3/2010 Berlin, MD Evergreen Cemetery 21. Signatur Fundal Service License 22. Name and Address of Facility The Burbage Funeral Home (2 mfs 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a conseque de of) Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2

No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 Yes 2 No uneral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending within 24 hours a er death.

To the Funeral Director: Aff
completed filled in by the fun 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -30-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

NOV 03

32. Registrar's Signature

GREGORIO M. BELLOSO; 5302 CHINABERRY DR., SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:58 M Year Physician/ Month William Everett Wilkins 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALI5B COM HOSPICE URY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2 □ F Min 5 /5 /1934 Country) 76 Director 218-30-0801 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland at Director ms 23a or 28a-f s must be notified MD Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a c Funeral 226 Maple Way 21804 USA 12. Was Decedent Ever in U.S. Argued Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important. If item 27 is marked other **- any injury or other traumany injury or other traumany. marked other than Elementary//Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allison Charles Wilkins Mattie Kate Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Wilkins/Wife 226 Maple WAy, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemeter v11/4/2010 Libertytown, MD of Funer ^{22. Name and Address of Facility} Burbage Funeral Home 108 Wiıliam St., Berlin, <u>MD 21</u>811 Si Service Licenses 23a. Part 1. Enter the disease, or complications that c , sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury pue to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f 2 No 9 Unknown 9 Unknown P.O. | s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has director, page 2 autopsy performed? death? 1 ☐ Yes 2 🛣 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 ☑ No Other: 4 \square Nursing Home 5 \square Residence 6 \blacktriangleleft Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DH3+1

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO,

29505

5302 (HINABERRY DR., SALISBURY, MD 21801

10-31-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Baby Boy Wilkerson 2010 0605 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mania SOUSOUR TENIN SULA KegloNAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Min. Country) Maryland 10/24/2010 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Wicomico Sharptown 1 X Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 404 Little Water St. 21861 USA items death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or Completed by 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: white Specify: 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) nla Be 17. Father's Name (First, Middle, Last, should be filed and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Brandon B. Brooks Miranda Brittingham 19a. Informant's Name/Relationship (Type, Print) Brandon Brooks/father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Little Water St., Sharptown, MD 21861 permit. Page 1 and 2 shu Department of Health an Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any injury or Salisbury Crematory 10/27/2010 4 Donation 5 Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a conf qualice of): disease or condition resulting in death) Medical **Examiner** Prevable in Eint 21 weeks actation Sequentially list conditions, Examine cause (Disease or linjury Due to (or as a consequence of that the death certificate be executed g physician and is the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending philor use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) 1 Yes 2 No g Unknown the P.O. þ signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, law requires 2 No 3 Probably 4 Unknown been signated the second the seco Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No To the Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death. the Funeral Director: After thi npleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

DHMH 17 Rev 7/2009

State

within 2.

To the F
complet

29b. Signature and title of certifier

A. Kimber Ly 5 31. Date filed (Month, Day, Year)

NUT 01

npleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

050902

SALISBURY Ma 21801

29d. Date signed (Month, Day, Year) 10-24-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36334 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert. Williams T.ee p^{M} 6:32 Medical November 2010 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 31442 Zion Road Parsonsburg Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 0370271965 Maryland Director 219-86-9036 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland filt and Mertal Hyglene. 27 is and ed other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31442 Zion Road 21849 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 salesman automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur H. Williams Sylvia Marshall 1 and 2 should be of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Williams/father 31442 Zion Rd., Parsonsburg, MD 21849 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 Durial 2 X Cremation 3 Removal from State Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/4/2010 21. Signature of Funeral Service Licensee ²²Name and Address Finding al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 6+ asteric disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Other (specify) Day Pregnant at time of death 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🗷 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manyler of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide $5 \square$ Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Caxtifying Nurse Practioner: To the best of my Incelledge, deaths 29b. Signature 29c. License number **D 6 6 198** title of certifier 11-03-2010

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

100 E. CARROLL St, SALISBURY, MD 21801

ess of person who completed cause of death (Item 23a) (Type, Print)

VGAIZA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 0 GRANVILLE CALVIN WILLIAMSON 30 2010 0355 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerse Pocomok F nder 1 Year | If Under 24 Hrs. AVIES ASSISTED LIVING Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Months Hours 1 **M**M 2 □ F SOMERSET Director Usual Residence of Deceden be filed within 72 hours after death with the Maryland ntal Hygiene.

4d other than "natural", or items 23a or 28a-f show event, the Pedical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Funeral Director 1 ☐ Yes 2 ☐ 1 0 WD HEBRON WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1890 ATHON 21830 USA Was Decedent Ever in U.S. Armed Forces? 1 Des 2 □ No If Yes, Give Year or Dates 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE Specify: Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MASONAry 7 is marked other traumatic event, u permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ 30HN THOMAS WILKIAMSON MARIE M. CANTWELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN LOKEY PINDERKIOMEN VILLE PA 18074 DAUGHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ASKIN COMETERY 11-5-2010 TYASKIN, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee Comprosed m MESSICK Funeral Home ROBOXGI BIVALLY MODISILY MO0416 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nd disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably √4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 DAK 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 ☐ Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a, Certifier 1 🖭 🗲 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

IVA

Barks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 0

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ Leonard Alexander Walker II 31 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner McHenry 538 Arra Messenger Lane Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday **Funeral** 4 / 24 / 1957 1 🔀 M 2 🗆 F Pennsylvania 217-66-9991 Director 53 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No MD Garrett McHenry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 538 Arra Messenger Lane 21541 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 ☐ Never Married 2 😾 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General 4 +Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard Alexander Walker Messenger Jean Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherrywood Add. Scott Depot, WV 25560 Patricia Newman/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/3/2010 Sang Run Cem. McHenry, Maryland 22. Name and Address of Facility Newman Funeral Homes P.A. Sonatury of Fugheral Service Licensee Malta 179 Miller st. , Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. Hitherosclerotio disease or condition resulting in death) Vacr5 Medical Due to (or as a consequence of Examiner Morbid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 hin 24 hours after deat the Funeral Director:

State

Medical

NOV - 1 Registrar

29a. Certifier

(Check only one

29b. Signature and title of certif

ite filed (Month, Day, Year)

Robert Goralski 311 N. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fourth St., Oakland,

1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D23979

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

within To the

124

State Registrar

DHMH 17 Rev 1/2001

7804

32. Registrar's Signature

Sinsur

Or-Apt. 440 Hangra MD21076

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEJ4

SAMIT

31. Date filed (Moi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 28, 2010 Physician/ WILSON 1:00 A M M JOSEPH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Golden Frederick Living 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours Min May 16 1927 83 Virginia 229-24-1713 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State **Funeral Director** 1 Yes 2 □ No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21701 United States 701 Northside Dr. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. White "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) Draftsman Manufacturing and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill tment of Health and Mental rant: If item 27 is marked 6 Dora Powell Charles L. Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 701 Northside Dr./ Frederick, Maryland 21701 Dorothy Wilson / Wife injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 XI Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. Oct.30,2010 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licenses 1621 Opossumtown Pike/Frederick, Maryland 21702 23a Part 1. Enter the disease or complications that cause snock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncertying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

and title of certifie

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) \(\) 36339 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month 12 ROMAN KENNETH WEIDE Nov. PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Maryland 213-28-4422 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ıral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD. Jarrettsville Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Baldwin Mill Road 21084 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Nuclear Energy permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert Weide Marie Welzant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21797 Woodbine, 16925 Old Sawmill Rd. Dawn Stone Gantt (Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Nov. 17, 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Middle River, 22. Name and Address of Facility E.G. Kurtz & Son Funeral Signature of Funeral Service Home, P.A. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final Tysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ that the death in the past 12 months? Month Year Pregnant at time of death Dav 2 🔲 No g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death.
Funeral Director: After this certificate has been sigr 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examine? Hospital 2 🗌 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Neick, work? 1 ☐ Yes 2 ☐ No. Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0036487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Bentman mo 500 Upper Chesapeake Dr. Bel Air, MD 21014 31. Date filed (Month 32. Registrar's Signature State Roman Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10727/2010 12:10 A^M MICHAEL PAUL YOUNG Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FORESTVILLE NURSING & REHAB. FORESTVILLE PRINCE GEORGE'S 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Days Min. 1 🔯 M 2 🗆 F Yrs Director /26/1955 212-68-2295 Montgomery Co.MI Usual Residence of Deceder 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified 1 X Yes 2 □ No Maryland Prince George's Fort Washington 5 10e. Street and Number 10g. Citizen of What Country? 23a 1012 Palmer Road # United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc. ð 'natural", or 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Contractor/Home Improvement Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Francis Young Belulah May Whiteside 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Nancy Young / Wife 1012 Palmer Road # 2 Fort Washington, MD 20744 or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o ₹ 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify 11/4/2010 Maryland Cheltenham, Maryland Veterans 21. Signatur of Funeral Service Licer 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HEAD INJURY INTERCRANIAL BLEEDING Medical Due to (or as a consequence of) Examiner BASAL SKULL FRACTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas performed? certificate 1 ☐ Yes 2xxx No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 V Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 X Accident 5 Pending LOWNSTATTS at November 26 I Director: A 2000 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ST 34 STEVENS Red. determined within 24 hours at

To the Funeral D

completed filled in owinds MO Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51520 11/3/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave. SE Washington, DC 20032

Registrar

State

31. Date filed (Month, Day, Year

NOV 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 09:23 AM **Physician** 2010 OCTOBER 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₩ M 2 🗆 F 56 Yrs. Dec.25,1953 Director Wash.,DC 578-66-1580 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director MD PG Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 7321 Serenade Circle United States by Funeral 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Immigration Officer Homeland Security th and Mental Hyc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be iment of Health and Menta tant: If item 27 Is marked Ellen Allen David L. Yeldell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Serenade Circle 7321 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. Melissa Clements-Yeldell/wife 1/wlife Clinton, MD.

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 11/3/10 Suitland, MD Cedar 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee Rd., Suitland, MD. 20746 3910 Silver Hill 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lyea disease or condition resulting in death) /Medicai Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 🗌 Ectopic pregnancy in the past 12 months? been signed by the atter should be detached for Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 **X**No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Nyes 2 □ No 24a. Was an autopsy has oerformed' 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 5 Residence 6 Other (Specify) ပ္ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: or Attending F s after death. I Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

CR 18

State Registrar

29b. Signature and title of certifier

SHARMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

29c. License number

RUS-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ ZRIKE M 201 <u>November</u> Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 **X** M 2 □ F Months Hours Min. MOROCCO 306-80-738 51 Director or 28a-f shov 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Medical Examiner must be notified at **Funeral Director** CKEYSVILL 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe or items 23a 2103 MOROCCO 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's injury or other traumatic event, the Mean ging. Elementary/Seconday (0-12) College (1-4 or 5+) GROUND BUSINESS 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) 2 TEBBAI MOUBAREK ZRIKEM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2103\mathcal{C}$ ZRIKEM SON REDMARE COCKEYSVILLE. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MOROCCO MARRAKECHI 4 ☐ Donation 5 ☐ Other (Specify) EN MUSLIM FUNERAL SER 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner venmeular Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): COVICUAL ischemna or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician arksu Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No a er death.

Director: // fter this certificate has No No 1 🗌 Yes 1 Yes 25. Was case referred to medica Be B 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗀 No မှ 1 Inpatient 2 PER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D2711 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2010 16 Lynsend Tot 30. Name and address of person who completed cause of death (Item 23a) (Type, Point) . Townsend, III 6701 31. Date filed (Month, Day, State NOV 0 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me, g909 21/19/2010 dbb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar Month **Physician** 9:07AM ichard Anderson 2010 JOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner more mau Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 212-44-864 Days Min. 1 2 M 2 □ F Months Hours mi Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1 res 2 No Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marita Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 MNo Specify <u>Ş</u> Blac 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 naincer 2 should be filed war and Mental Hygie 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 911 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is
any injury or other trai Owings Mills MD 21117

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, grematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State Baltimore 11-12-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Varahn C. Greene 21. Signature of Funeral Service Fundral Services allstown, mo 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mansure 1 day disease or condition resulting in death) nemossin /Medical Due to (or as a consequence of): 3 day Examiner LEATHER HONORED BY MEDICAL EXMINIER On phay racal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a d be detached for P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen diac 24a. Was an Were autopsy findings available prior to completion of cause of death? certificate has hirector, page 2 s autopsy performe 2 **N**0 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**X**Yes 2XNo 1 ∏ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ieral Director: After this (filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifler Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License numbe larmi Iyer NOVEMBER 2010

Registrar DHMH 17 Rev 1/2001

State

LAXMI 31. Date filed (Month, Day, Year)

NOV

racke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 201

32. Registrar's Signature

8009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov 13, 2010 7:30a M Angela Alston Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown 9115 Sunset Ridge Road 8. Date of Birth (Month, Day, May 29, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Min. 1 . M 2 . F Months Hours Country) Maryland Director 212-80-7715 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Tes 2 ☐ No Randallstown **Baltimore** Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21133 9115 Sunset Ridge Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 6 þ 1 D Never Married 2 Married 1 Yes If Yes, Give 2 😾 No 21215-0036 1 ☐ Yes 2 X No Specify: Black Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) Millie Johnson Jessie Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9115 Sunset Ridge Road Randallstown, Maryland 21133 Millie Johnson altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Md. 11/19/10 Western Star Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. art 1. Enter the disease, or complications that caused the ock, or the relation of the cause on each line. Immediate Cause (Final death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ lung disease or condition Medical resulting in death) Due (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an positive autopsy performe heroin 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical of Vital To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nume Practioner To the best of my knowledge death on det the time. date and place, and due to the cause(b) and mainer as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) amille Menino CRNP Hospice 828 North Entaw St. Battomeremi 82 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 17, 2010 1:19 A. M Janet Lee Andrathy Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Jpper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 178-26-4560 Hours July 6, 1 M 2 XF Months ቸ932 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 1210 Maryland Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 Cass Court 21015 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 You Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Schools life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teachers_Aide Balto. County Public Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Louis Jacob Miller, Jr. Janet A. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 13205 Bridale Avenue Baltimore, Maryland 21220 Leslie Andrathy / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State emetery, crematory or other place) injury or Bel Air Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bel Air, Maryland Funeral Service Licensee 21. Signature Evans Funeral Chapel & Cremation Services-Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** กบงงา Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Pulmonari nknum Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Hipothynoidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Dementia 24a. Was an Were autopsy findings available prior to completion of cause of autopsy artern disease death? mary 2 2 No _ Yes To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Manpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 / No this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hor To the Fune completed fi (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Upper Chesapeake Drvy Bel Fistle MY 32. Regis State Registrar

DHMH 17 Rev 7/2009

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Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Md

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examinar mass harmonials.

Baltimore, Maryland 21215-0036

and the as use

as been signed by the 2 should be detached has ' page within 24 hours after death.

To the Funeral Director: Af

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enies Underlying Cause, Disease or injury that initiated events resulting in death) Last	b								
IF_FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ecto 4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown	opicpregnancy er (specify)		23d. Date of de Month	livery Day Year				
Part II. Other significant conditions of		oacco use contribute to the cause of death? es 2∑X No 3 ☐ Probably 4 ☐Unknown							
-			24a. Was an autopsy performed? 1□ Yes 2 🔼 N	prior to death?	utopsy findings available completion of cause of 2 No				
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at 28 Work?	3d. Describe how in	jury occurred	,				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, f building, etc. (Specify)	3f. Location (Street and City or Town, Sta	et and Number or Rural Route Number, State)						
29a. Certifier (Check only one) 1 ★ Certifying Ph 2 Medical Exam	nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ar gation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)				
29b. Signature and title of certifier	29c. License number	29d. D	d. Date signed (Month, Day, Year)						
Dany Scha	len cant	R118354	11	/18/201	0				

Registrar DHMH 17 Rev 1/2001

State

30. Name and appress of person who completed cause of death (Item 23a) (Type, Print)

Amy schuler chur

NOV 19 2010

31. Date field (Month, Day, Year)

7900 Oak Point

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G909 11/23/10 Jh
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year NOVEMBER Katherine Byrd 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death ST. AGNES HOSPITAL BALTIMORE TIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Sept. 15, 1961 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F MaryTand Yrs **Director** 49 220-32-7320 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 625 North Bentalou 21216 Street r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify:Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police Dept. 12th Grade Pre-Trial Investigator ye 1 and 2 should be filed wit tof Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Garnet Bazemore Elouise McCrav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garnet Bazemore - Father 625 North Bentalou Street Baltimore, Maryland 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o Burial 2 Cremation 3 Removal from State Arbutus Memorial Park 11/19/2010 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, Maryland ^{22. Name and Address of Facility} Chatman—Harris Funeral Home 5240 Reisterstown Raod Baltimore, Maryland 21215 21. Signature of Funeral Se 23a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
OOAYS Immediate Cause (Final SEPSIS Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner URINARY INFECTION DAYS TRACT Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Disk to for each nonscriptions of igned by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year 1 L Yes 2 L been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEMO THORAX $eta \gamma \mathcal{R}_{\mathcal{L}}$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💢 No Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check NOVEMBER. eth a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AUENUE BALTIMORE, MARYLAND 900 KATHERINE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 20 PO 3:10 November Ам Kenneth S. Battve Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** N/A Roland Mews Baltimore Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🙀 M 2 🗆 F 97 Months Hours June 25 ^Y¶913 217-16-7577 EngTand Director Usual Residence of Decedent show 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23a or 28a-f show ant If item 275 is marked of other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director **Baltimore** 1X Yes 2 ☐ No Marvland N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21210 U.S.A. 14 Roland Mews Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Broker Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Susannah Shaw Stanley Battye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 College Ave. Lutherville, Maryland 21093 Susan A. Battye / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date Hilltop Service Corp. 1 Burial 2X Cremation 3 Removal from State 11-17-2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funer 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Domen 1 19 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and stached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Lyes 2 = 9 Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed this certificate 2 No 1 🗌 Yes Yes 2 L ours after death.

eral Director: After this certific.
filled in by the funeral director, t 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 **To the** I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 35102 OU 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mar DONM-D CHav Mall 5901 North Date filed (Month, Day, Year) NOV 1 9 2010 Registrar

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DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wonth Marie Leonard S. Brushwood Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carrol1 Westminster 5. Social Security Number 216-38-3131 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Md **Funeral ⊠**M 2 □ F 69 Days 0470171941 Md. Director Usual Residence of Deceden 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Carroll Md. Eldersburg 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1236 Seron Court 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1 O Baltimore, Maryland 21215-0036 Year or Dates. 1959 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced er than "natur, the Medical E Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Springfield State Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Dept. Hospital is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard S. Brushwood Sr. Margaret Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 Maple Grove Rd. Hampstead, Md. 21074. Leonard S. Brushwood III(SON) item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 11/19/2010 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Sykesville,Md. 4 ☐ Donation 5 ☐ Other (Specify) P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one are not on each lin. Approximate Interval Between Immediate Cause (Final SIZATE Onset and Death Physiciani disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown g Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No М 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours

To the Funeral Medical 29a, Certifie certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Chec Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only o Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 CHARLES SPENCER BARRINGER 10:50 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Abingdon 2809 Emmorton Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours Min. (Month, Day, Ye Arkansas Director 454-42-6867 88 Sep. Usual Residence of Decedent 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🎦 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2809 Emmorton Road 21009 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Ordnance Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked မ Daisy (unk) Meggs Edmond (unk) Barringer other traumatic permit. Page 1 and 2 should to Department of Health and Me Important; If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2811 Emmorton Road, Abingdon, MD 21009 Frank D. Barringer / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cromation 3 ☐ Rer injury or 11-22-10 Bel Air, Maryland Bel Air Memorial Gdn 4 Donation Othey (Specify) McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PIRATION Physician disease or condition Medical resulting in death) Examiner OVER 104em Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ or Attending Physician; The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 L 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 2 🗌 No **Division of Vital** To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after Hospital 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi only one) 29b. Signature and title

State Registrar

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32. Registrar's lignatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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NEVEMBER 17, 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 17, Physician/ 1:16 AM 2d10 Roxie Theadora Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casa de Rosa Assist, Living Howard Savage 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral ^{Year)}1949 Days Min Month, Day Dec 20 1 □ M 2 🔀 F Florida 60 Director 221-36-6695 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🔀 No Howard Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10124 Highridge Road 20723 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural", White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the Blinds Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Hannah Bent Charles Bell Houston permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Ruth Brown /Daughter 1670 South Shelter Trail Merritt Island, FL 32952 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 22 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State . Delaware 4 ☐ Donation 5 ☐ Other (Specify) Roxanna Cemetery 2010 1401585 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Keloo 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the burial-tran Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for in the past 12 month Pregnant at time of death Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe Yes 2 2 Yes 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medica director, 26. Place of Death (Check only one) Be Hospital Other: 2 1 1/6 1 Tyes ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence After this within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) E

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Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Day Physician/ Frances C. Butler NOV Month 2018 1:30a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 577-60-2985 1 🗆 M 2 💢 F 84 Month, Day, 5/15/ 1926 Director MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified Wash DC Washington DC Washington D.C. Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2402 Branch Ave 20020 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2XXNo Yes, Give Maryland 21215-0036 Specify: Black 1 Yes XIX No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Health Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname)
Frances Butler 17. Father's Name (First, Middle, Last) Edward Betts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Holiday Ave Ft. Washington MD 20744 Robyn Butler Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Atlantic Crem 11/10/10 Glen Bernie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Simplicity Crem&Fun Service ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jiscase Ph_sician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No should be detached 9 Unknown 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autons certificate has page 2 performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Mann Death 28b. Time of Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certi ing Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Me, cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Merical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Cyclifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) certifie 29b. Signature and title 29c. License number 30. Name and address of se of death (Item 23a) (Type, Print) ana

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State Registrar 31. Date filed (Month Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Departmentoof Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 20 °f o A^{M} Mary Jane Brown 6:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Care 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) 02/26/1936 74 Director 215-32-5282 Marvland Lisual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits Director Maryland Harford Havre de Grace 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral items 23a 1113 Leslie Dr 21078 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black White etc. ō 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bank Manager Banking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Hartman Emily Jourdan Page 1 and 2 should b thent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Brown / Husband 1113 Leslie Dr. Havre de Grace. MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place)
Harford Mem. Gardens 1 X Burial 2 Cremation 3 Removal from State 11/9/2010 4 Donation 5 Other (Specify) Aberdeen Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by carcinana 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 M No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 년. Other: 4 In Nursing Home 5 In Residence (20) Other (Specify) WSPE 2 X No 1 🗌 Yes 1 Inpatient 2 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMES N. Chanles ST 6701 NOV 08 2010

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Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 1^{Day} 2010 рм Teddric Lionel Childs 5:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 3816 Ridgewood Avenue Baltimore 5. Social Security Numbe 6. Sex 1 M 2 □ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours ^{Ye}1983 March, 28, Director 27 Mary land 220-02-6266 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3816 Ridgewood Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗹 No If Yes, Give Year or Dates. Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation Baltimore County (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Special Educator 4 <u>Years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Pamela Kelson Calvin Leonard Childs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Pamela Childs - Mother</u> 3816 Ridgewood Avenue Baltimore, Maryland 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery | 11/20/2010 | 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, Maryland 22. Name and Address of Facility Chatmen Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, Maryland 21215 Part 1. Enter the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or ilnjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ completed filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 📿 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 S S 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ants 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Finksblug 8/14 hilip Baltimer 202 31. Date filed (Month, Day, 32. Røgistrar's Signature State Registrar DHMH 17 Rev 7/2009

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TERRIC

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G909, II/23/2010, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eleanor Mae Coffer М 2010 November 14, 7:35A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death
Baltimore Gildhrist Center Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 1 M 2 XF Director 69 213-42-4921 19, 1941 Baltimore, Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Essex **Baltimore** Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21221 1204 Handsworth Place Apt. A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 √ No Specify: White Specify: Completed 3 Divorced Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Assembler BDBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harriett Viola Marsh ည Andrew James Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Foxcroft Lane Baltimore, Maryland 21221 Donna McGee (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. Evans Funeral Chapel 1 Durial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 21, 2010 Nov 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Crematica
16924 York Road Monkton, Maryla

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Evans Funeral Chapel & Cremation Services-Monkton 16924 York Road Monkton, Maryland 21111 Approximate Interval Between Immediate Cause Pinal Onset and Death Ph sician/ Acute Myeloid Leukemia disease or condition vears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) ☐ Pregnant at time of death ☐ Unknown Month Day Year 9 signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be director, page 2 s autopsy performed' 2 No Yes 2 V No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square XOther (Specify) Hospice 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the I only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) D71040 November 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. 6701 Charles Street Towson, Maryland 21204 Arathi Kumar

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Leanor 1025 AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 3, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Months Days 212-40-7232 1 - M 2 X F Director 68 Baltimore. MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 8659 Ridgelys Choice Drive U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. permit. Page 1 and 2 should be filed within 72 hours after teppartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Baltimore County School Teacher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Armstrong, Sr. Ellen White 19a. Informant's Name/Relationship (Type, Print) Husband | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8659 Ridgelys Choice Drive, Baltimore, MD 21236 Philbert Crawford, Sr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Moreland Memorial
Park November Donation 5 Other (Specify) Parkville, Maryland 2010 22. Name and Address of Facility
Evans Funeral of Funeral Service Licensee Chapel & Cremation Services Harford Road, Parkville, 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between ate Cause (Final Onset and Death ₽nysician/ disea or condition recomp in death) Cholana 10 carcupano Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No I Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔽 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Secretifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number anh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 32. Registrar's Signature State arks **NOV 19** Registrar

DHMH 17 Rev 7/2009

1- For Amend Items 25,27,28a-1 per me, g9.09 11/19/2010dnb Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** :15 AM Carol Ann Chase Oct. 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LEVINDACE Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F 69 Director 188**-**34**-**7838 7. 1940 Maryland Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 201-F Crocker Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Specify: ð 3 Widowed 4 □ Divorced "natural", White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) سمن Mental Hygiene. ۱27 is marked other than "، r traumatic even Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Parks Chase Beverly Anne Bodet ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trauonce. Gina Shaffer / Attorney 207 Fulford Ave., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Hilltop Service Corp. 4 □ Donation 5 □ Other (Specify) 10-14-10 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Varnety out weeth nel Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9∏Unknown ld be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records. QUADREPLEGIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1

Inpatient 2

ER/Outpatient 3

DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 X No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 2 Accident Injury Subject fell March,2010 1 ☐ Yes 2 X No Unknown M within 24 hours after death.

To the Funeral Director: #
completely filled in by the for 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number of Rural Boute Number Dr. City or Town, State) 4 Homicide Bel Air, MD 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063327 Phirty It WORDETHEURT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLDEHIWOT, MD 2434 W. BELVEDERE HUE, BALTIMORE, MD GIZHW 31. Date filed (Month, Day, Year) State OCT 1 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-08454 John Cowan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Cowan	1- For State	Certificate of	f Health and Mental Hy f <i>Death</i>	Reg. No. 20	110 3535			
Physician		Tr		2. Date of Death	3. Time of Death			
ledical Examine	4a. Facility Name (if not institution, give street an		4b. City, Town, or Location of Death	Month Day Year November 5, 2010	0333 hrs			
	Baltimore Washington Medical Ce		Annapolis	Anne Aru				
Funeral Director	5. Social Security Number 2 2 0 - 5 0 - 6 5 8 7	7. Age (In yrs. last birthday) F 61 Yrs	Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 12/28/1948	9. Birthplace (State or Foreign Country) MD			
ž.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati			10d. Inside City Limits			
d dow any	MD P.G.	Brandywi			1 Yes 2 No			
the Maryland a or 28a-f show	10e. Street and Number		10f. Zip Code	10g. Citizen of Wha	t Country?			
3a or 2		D	20613	USA				
r death with or items 23	11. Marital Status 12. Was Armed 1 Never Married 2 Married 2 Armed 12. Was Armed 12. W	ed Forces? If Y	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto		American Indian, Black, etc.			
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215-0036 be filed within 72 hour that Hygiene. ked other than "natuent, the Medical Exar	17. Father's Name (First, Middle, Last)	1400		(First, Middle, Maiden Surname)	zz bupporein			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		Sr.		Mae Buford				
hould hould Me is ma	19a. Informant's Name/Relationship (Type, Print	Daughter 1240	Address (Street and Number or F					
e, MD I and 2 sho Health and item 27 is	20a. Method of Disposition		ition (Name of cemetery,		City or Town, State			
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr	1 Burial 2 Cremation 3 Remov	ral from State crematory or oth Atlantic	· · ·	/10/10 GlenBe	ernie MD			
altin mit. P partme portan	4 Donation 5 Other Specify: 21 Sensors of Funeral Service Licensee		lame and Address of Facility Sin					
E E E E	Ithon Allen	1111	Omasattenea /	<u> 190 Riage RD 1</u>	Hanover MD			
Physician	23a/Part I. Enter the disease, or complications the failure. List only one cause on each line.				Approximate Interval Between Onset and Death			
Examiner		tensive atheroso	eleortic cardiova	scular disease	Death			
	Sequentially list conditions.							
	of any, leading to immediate Due to (or cause. Enter Underlying Cause	as a consequence of y:						
si sq	if any, looking to himselfels cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying							
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60, ate be ex obysician te burial	IF FEMALE: 23c. If y	3a,PII,27,per ME	E g910 12/13/10 1	23d. Date of de	elivery			
Sox 6876 leath certificate e attending phy for use as the b	23b. Was decedent pregnant in the past 12 months?		tal death 3 Ectopic pregna ner (Specify)		Day Year			
Box e death of the atter	1 Yes 2 No 9 Unknown g U							
P.O. Bost that the designed by the set detached for			nderlying cause given in Part I.	23e. Did tobacco use contribu				
S, P.(Diabetes mellitus;	obesity		1 Yes 2 No 3 24a. Was an 24b. We	Probably 4 Unknown			
Records, The law require frate has been si	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓							
tal Rec			OC Diago of Dooth (Chaolice	1 ✓ Yes 2 No 1	Yes 2 No			
of Vital ng Physician: After this certi	25. Was case referred to medical examiner?	Inpatient 2 ✓ ER/Outpatient	26.Place of Death (Check of Donald Other) Nursing		Other:			
of \langle	7 Norman of Doubt							
ttendii death.	1 X Natural 5 Pending 2 Accident Investigation		1 Yes 2 No					
Division or spiral or Attending hours after death. Inneral Director: After y filled in by the fune	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, Cor Town, State)							
D thospital	298. Certifier Courte to the first to the best of my knowledge death accurred at the time date and close and due to the accuracy's and manner as atotach							
To the Ho within 24 To the Fu complete!	(Check only 2							
F 3 E 8	29b. Signature and title of certifier		29c. License number		(Month, Day, Year)			
	W		O.C.M.E.	November 5	, 2010			
Unino	30. Name and address of person who completed Donna M. Vincenti, MD Assistan	·	Penn Street, Baltimore, M	D 21201				
√ ~	I DOUBLA IVI. VIIICELLII. IVID ASSISIAI							

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ORIGINAL

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		1- For State Certificate of Death	,,	Reg	g. No.			
Physici	an/	1. Decedent's Name (First, Middle,Last)		Date of Death)	3. Time of Death		
edical Exami	ner	Robert Alan Doucette		Month November		1304 hrs		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 428 Starwood Drive # E Glen Burnie	of Death		4c. County of Dea			
Funeral			der 24Hrs. 8	B. Date of Birth	(MM/DD/YYYY) 9. E			
Director		Months Days Hou	re Min	05/16/1	Fore	eign Country)Maryland		
		Unknown 1XM 2 F 45 Yrs. 1		0)/10/.	1907	Maryland		
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits		
	_	MD Anne Arundel Glen Bur	rnie			1 Yes 2 No		
Maryland 28a-f show	Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	ountry?		
th the Maryland 23a or 28a-f sho notified at once.		428 Starwood Drive, Apt. E 2106	1	7	United Sta	ites		
with ms 23	-E	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or 15. Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Or 15. Never Married 2 Married Proces?				erican Indian, Black,		
death or ite	Fune	1 Yes 2X No		an, etc.)	White, etc.	nite		
s after ral", riner	ğ	3 Widowed 4 Divorced of Divorced of Divorced of Divorced of Dates:			Specify:			
5-0036 led within 72 hours Hygiene. other than "natus	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give during most of working life, DO NO			16b. Kind of Busines	s/industry		
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ed with	Completed		er's Name (Fi	rst, Middle, Ma	aiden Surname)			
215 be file ntal H rked e	Be	Stanton L. Doucette Lo	is E.	James				
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mernal Hygiene. 127 is marked other than "natural", or items 23a or 28a-f shown whatic event, the Medical Examiner must be notified at once	ျ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	mber or Rura	al Route Numb		te, Zip Code)		
MC d 2 st lith ar m 27		Susan R. Sherman / Sister 2512 Carroll St.,						
ore, tree		20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	0	ate	20c. Location - City	or Town, State		
Page nent c		4 Donation 5 Other Specify: Metro Crematory Inc.	11/1	5/201d	Baltimor	e, MD		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility	ty Crem	ation S	Society of	Maryland		
		299 Frederick I 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	Rd., Ba	altimo	re, MD 212	228 Approximate Interval		
Physician // // // // // // // // // // // // //		failure. List only one cause on each line.	cardiac or re	spiratory arres	st, snock, or near	Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death		
		Sequentially list conditions, b				7.1		
	Je.	if any, leading to immediate Due to (or as a consequence of):						
0	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				-		
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Box 68 e death certif the attending ed for use as		1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			1			
that the cred by the detached	Phy.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.	23e. Did tobacco use contribute to the cause of death?				
, P.O ires that t signed by	d b	Morbid obesity, cardiomegaly		1 Yes	2 No 3 Pr	obably 4 🗸 Unknown		
rds requ	ete			24a. Was an autopsy		utopsy findings available completion of cause of		
Records, The law require figure has been singuised to be a second to page 2 should to be a second to be a seco	Completed			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No				
tal Rec sian: The certificate ector, page	Be	25. Was case referred to medical 26.Place of Death	(Check only					
of Vital ng Physician After this certi meral directo	TO B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4	Nursing He	ome 5 R	esidence 6 🗸 Oth	er: Scene		
n of ing Pl After funera		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Wor (Month, Day, Year)	_	d. Describe ho	w injury occurred			
IVISIOF or Attend after death Director:	äţi	2 Accident Investigation						
Division tal or Attendi ts after death.	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, e	etc. 28f	t. Location (Str or Town, Sta		tural Route Number, City		
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certifi 24 hours after death. Funeral Director: After this certificate has been signed by the attending	ပိ	4 Homicide (Specify) 29a. Certifier (Cherck only: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pi	lass and due	to the source	(a) and manner as at	tod.		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	se(s) and manner as stated. and place, and due to the cause(s)						
and manner stated. 29b: Signature and title of certifier 29c. License number 2						29d. Date signed (Month, Day, Year)		
	1	Children O.C.M.E.			November 16, 2	2010		
	H	30. Name and address of person who completed cause of death (Item 23a)						
)		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201	1				
		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regis	T G L	MATA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene region, 11 19/2010 dhb Reg. No. For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**)√2**√M 2 □ F 66 Yrs Philippines May 4, 1944 225-37-6199 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Jarrettsville 1 ☐ Yes 2X No Maryland Harford 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3814 Jarrettsville Pike 21084 Philippines Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 Filipino 1 ☐ Yes 2XXNo Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmaceuticals 12 Chemical Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Juanita Orcilla Tiburcil Delacruz ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) 3814 Jarrettsville Pike Jarrettsville, Maryland Gloria Siason-Delacruz/wife 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Evans Funeral Chapel – Bel Air 1 Burial 2Cremation 3 Removal from State 8, 2010 Forest Hill, Maryland 4 Donation 5 Q Other (Specify) 21. Signature Service Lice Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Subdura Immediate Cause (Final hematomo **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL E Examine Due to (or as a consequence of) use as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be +23a+1+a Division of Vital Records, P.O. Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 🗌 Ectopic pregnancy Live birth be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 🗌 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 🗌 No certificate or Attending Physician: 25. Was case referred to medical examiner?
1 Xes 2540 26. Place of Death (Check only one) Be Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 🗆 DOA မ this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 24 hours after death. Funeral Director: After 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chael CI.MMin 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) N3V 1 9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ nn 2010 1am Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Pice estminster Jouse Dove If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code Ridg ewood 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manutacy ware Be 17. Father's Name (First, Middle, Last) ဂ္ Dunne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Susan 90 other 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Hanover Funeral Ser ice Licenses Signature PA 17331 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ LUNG Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Examiner Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) as the burial attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) DIVE HINGE မ 4 - Nursing Home completed filled in by the funeral 28b. Time of 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗆 No M Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only, 29d. Date signed (Month, Day, Year) 29b. Sign 11/18/10

State
Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Center St weson A STY MD

s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1^{2} 7:05 a_M 2010 Helen R. Eley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2305 E. Madison Street Baltimore na If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 1939 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 □ M 2**X⊃X**F Country) **Director** 216-34-5806 71 N.C. Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Baltimore na 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 2305 USA E. Madison Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: 3 Widowed 4 □ Divorced Completed Year or Dates. id Mental Hygiene. marked other than "natur matic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most is saibled life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. James Brown Ethel Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Williams-Daughter 2037 Ellsworth Street Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 9ther (Specify) Balto, MD 21202 11-19-10 21. Signature of Fun Service 22. Name and Address of Facility March East 1101 E. North 21202 Avenue Balto, 23a. Part 1, Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINOMA Physician/ Due to (or as a consequence of): disease or condition resulting in death) 27 VIS Medical Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Due to for as a consequence of sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Not: 12,2010 Due to (or as a consequence of): physician sthe burial Physician/Medical nding p attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Year 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death signed by the a d be detached for Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bymora 1 ☐ Yes 2 ☐ No 3 💢 robably 4 ☐ Unknown dostructure Completed Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law cate has page 2 s autopsy performed? Yes 2 death?
1 Yes 2 No certificate 25. Was case referred to medica Division of Vital director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 DR Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work? 1 ☐ Yes 2 ☐ No 5 Pending injury 1 Natural 2 Accident
3 Suicide
4 Homicide n 24 hours after death. le Funeral Director: A bleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗔 within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-13-2010 DO. H0062554 Richey Hospice Joseph 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STreet Cynth: A shen 838 N. EUTAM Baltmore, MD

Registrar

31. Date filed (Month, Day, Year NOV 19 2010

27201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36364 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November Physician/ Richard Charles Ely 2010 4:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 6829 Ridge Rd. Marriottsville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Davs Hours April 20, Country) 81 MD **Director** 220-20-1394 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Marriottsville 1 🗌 Yes 2 🔣 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21104 6829 Ridge Rd. United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2XXMarried XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: White Completed 3 Divorced 4 Divorced WWII Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Fire Fighter Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Vomastek John Walter Ely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6829 Ridge Rd. Marriottsville, MD 21104 Nancy Ely (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 11/22/2010 Sykesville, MD Lake View Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory 1212 W. Old Liberty Rd. Winfield, MD 000 23a. Paul 1. Enter the disease, or complications that caused the death. Do not eater the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and deelached for use as the hural-trand that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of autopsy 2 7 2 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital 2 No မ 1 Yes 1 Inpatient 2 Inpatient 3 Inpa After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? injury 5 Pending 2 🔲 No ☐ Accider☐ Suicide Accident Investigation after death 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

21/36

address of person who completed cause of death (Item 23a) (Type, Print)

w

32. Registrar's Signature

-TRICIC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Medical Examiner The opening in the part of the part	Catherine Fleetwoo	1- For State Contificate of Death									
According to the property of	Physician/	Registrar 1. Decedent's Name (First, Midd	lle,Last)					2. Date of Dea	th	3. Time of Death	
So The Control Street of an industry street in the Control Street			M. Fleetw	boo				Novembe	r 13, 2010	0900 hrs	
The part of the		4a. Facility Name (if not institution	on, give street and numbe		4		ocation of Death		4c. County of Dea	th	
Use Section of Courty MD Section of Section of Courty MD Section of			6. Sex 7. A	ge (In yrs. las	t birthday)				rth(MM/DD/YYYY) 9. B	irthplace (State or	
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 1 perpHYS, G911, 1/28/2011, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) **Robert Karl Fritzsche**Robert Carl Fritzsche 2. Date of Death Physician/ Month Day 2010 14:00 Nov Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore 101 E. Elm Avenue Overlea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours Min 1 🔀 M 2 🗆 F 220-46-3263 **Director** 58 MD Usual Residence of Decedent or items 23a or 28a-f show aţ 10a. State 10c. City. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 Tes 2 X No MD Baltimore Overlea 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 101 E. Elm Avenue 21206 U.S.A. should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black. White, etc. 1 Never Married 2X Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced White Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 5+ Architect Professional Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Richard Fritzsche Isabella Frances Gliniecki permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21206 101 E. Elm Ave., Lori Fritzsche (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4

✓ Donation 5 ☐ Other (Specify) 11/16/10 Medcure Inc. Orlando, FL Signature of Fundad Service License 22. Name and Address of Facility 32809 Medcure 205, Orlando, FL 8018 Sunport Dr.,Suite 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final AMYOTROPHIC SURROSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law lequires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown Completed 24 hours after death. Funeral Director: Adter this certificat has Leen sieted filled in by the funeral director, page 2 s rould I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my course at the time, date and place, and due to the cause(s) and manner as stated.

2 U Medical Examiner: On the basis of examination and/or investigation, in my cocurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c. License number Clouded MSN CRNP

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 192010

ROL5860

LORA L. CLAWSON MIN LENT TROPE RM SO FOR LOI N. CAROLINEST BALTO, NO 2287

Newscogy-5m Fr

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #5 Per FH C910 12/09/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** PM arence 3010 November 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 5, 1943 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours Min 1 XM 2 - F Yrs Maryland 67 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No **Baltimore** Director N/A Maryland 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If tem 27 Is marked other than "natural" any injury or other traumatic event." 21205 U.S.A. 619 Robinson Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc 1 Yes 2 y
If Yes, Give
Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Black ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mt. Claire House Counselor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Emma Lee Gross** Richard Gross ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Robinson Street Baltimore, Maryland 21205 Elizabeth Gross 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 11/23/10 Catonsville, Maryland Metro Crematory, Inc. 4 Donation 5 Other (Specify) Funcial Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part . Enter the disease shock, or heart failure. L or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter U daying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed use as the bunal-transit resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3

Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably should I Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 5 Residence 6 Other (Specify) Certification: To after death.

Director: After this funeral 27. Manner of Death Injury at Work? 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury Attending 1 X Natural 1 🗌 Yes 2 🗌 No 2 Accident filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ö To the Hospital within 24 hours a To the Funeral E 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5-000 November 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Yea Katherine Darlene Gaskins 821 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITA Baltimore Rosedale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) May 12, 1952 1 🗆 M 2 💢 F Months Hours Min. West Virginia Director 232-86-1507 58 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 □ No WestVirbinia Marion Fairmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 26554 U.S.A. 715 Ohio Avenue Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc þ 1 Never Married 2 XMarried ี GaS Kins Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Medical Receptionist is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred June Aumiller Lorn H. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7150hioAvenue, Fairmont, WestVirginia 26554 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Thomas E. Gaskins/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-22-10 Fairmont, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) .ZionCemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muchael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) Percarbia disease or condition resulting in death) Medical Examiner DOXICA Sequentially list conditions, if any, leading to immediate cause East U Jarying Cause (Disease or iinjury Examiner arrest Hospital or Attending Physician: The law lequires that the death certificate be executed espirator the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of attending physician for use as the burial Physician/Medical rcoidosis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown een 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed After this certificate ie Nopers. in 24 hours affer death. the Funeral Director: After this certificate in a filed in by the funeral director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗀 No Investigation 6 \square Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day. Year) ma 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 900 Mccluskey FRANKLIN SQUARE DR Balto CourTret

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 1

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	te of Maryland /		tificate of D			2010	36369			
	Physicia		1. Decedent's Name (First, Middle, Last) John Lloyd	Griffith, S	r.			2. Date of Death	-1 ⁿ 5 ^y , 20 řto	3. Time of Death 6:32 pm M			
	Medic Examin		4a. Facility Name (if not institution, give street an Carroll Hospice Dove	d number)		4b. City, Town, or		110 (0 5 0.1	4c. County of Death				
	Funeral	i.	5. Social Security Number 6. Sex	7. Age (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Carroll 9. Birth	place (State or Foreign			
	Director >		Usual Residence of Decedent	51	Yrs.	Indiano Bayo	Tiodio William	Jan 14,	1959	PA			
	aryland ta-f sho ifled at	Director	10a. State 10b. County MD Carrol1	10c. City, Tow		ville				10d. Inside City Limits 1 🕅 Yes 2 □ No			
	th the M 3a or 28 t be not	al Dir	10e. Street and Number 7419 Second Avenue			10f. Zip Code	784	10	g. Citizen of What Cou US				
	leath wi	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. ed Forces?	13. W	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	can Indian,			
3-003p	s after c ral", or Examin	by	1 Never Married 2 Married 1 If Ye	Yes 2 V No s, Give or Dates.		Yes 2 No		nican, etc.)	Black, White,	etc. ite			
2-0	72 hour n "natu Medical	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of work	ing 1	6b. Kind of Business Ir	dustry			
7 7 7	d within lygiene. ther tha nt, the l	Be Col		gge (1-4 or 5+)		communica			Federal E	xpress			
yland	d be file Mental H arked of tic ever	To B	17. Father's Name <i>(First, Middle, Last)</i> Frank Bohenek					e <i>(First, Middle, Ma</i> inia Vac	iden Surname) :carella				
Man	2 shoull thand Ith and Ith and Ith than		19a. Informant's Name/Relationship (Type, Print) Mrs. Donna Griffith (S						ity or Town, State, Zip	Code)			
ore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Place of	of Dispos	sition (Name of		Date 2	MD 21784 Oc. Location - City or T	own, State			
Бапптог	mit. Pag partmen sortant: 'injury :e.		4 Donation 5 Other (Specify) St. Mary's Byzantine Cath.: 11/19/2010 Taylor, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HATCHT FINERAL HOWE & CHAP										
Ď	Der Img		Drian C. Hay	+ M00764	1	PO Box 19	5 Sykesv	ille, MD	21/84	Approximate			
F	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on an line. Immediate Cause (Final disease or condition												
	Medical Examiner		resulting in death)	ue to (or as a consequence		•		= = = = = = =		-			
	p #	Examiner	cause. Enter Underlying	io tu (ur es a cunsaçuanda	ofyr								
	execute an and rial-trans	l Exar	Cause (Disease or iinjury that initiated events c c Du	ue to (or as a consequence	of):								
200	cate be physicia the bur	edica	d										
00 00	th certifi ttending or use a	Physician/Medical	in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal deat		Ectopic pregnancy	,		23d. Date of deliv	ery Day Year			
D	the dea by the a ached fe	hysic	1 Ves 2 No 4 4	Pregnant at time of death Unknown	5 🗆	Other (specify)			WOTH	Day fear			
ָרָ ה'	ires that signed d be det	d by F	Part II. Other significant conditions contributing CARNO PA		in the ur	nderlying cause give	en in Part I.		cco use contribute to t				
scorus,	aw requias been	Completed by						24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of			
ב ב	un: The l lificate h or, page		25. Was case referred to medical			26. Pla	ce of Death (Checi	1 Yes 2	ed? death?	2 9 No			
N 110	Physicia this cert al direct	: To Be	examiner? 1 Yes 2 No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/O Date of injury 28b.	utpatient	3 DOA Cther	r: 4 Nursing Ho	ome 5 🗆 Residenc	ce 6 Other (Specify	INPAMENT			
	ending eath. or: After he funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation		injury	28c. Injury work? M 1 □ Y	es 2 □ No	28d. Describe how	injury occurred	fac > 1 le			
	al or Att s after de l Directe d in by t			Place of Injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,			
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the	e basis of examination and/	or investi	gation, in my opinior	n, death occurred at	the time, date and p	place, and due to the ca	use(s) and manner stated.			
	To the Within To the COMP	Σ	only dne) 3 L Certifying Nurse Practic	MY MON	rieage, ai	29c. License	number	290	d. Date signed (Month,	Day, Year)			
			30. Name and address of person who completed	cause of death (Item 23a)	(Type, Pr		392		11-16-1 , MD 2				
	Stat	ρ.	Flavio Kruter, M.D. 31. Date filed (Month. Day March				7 1005	minster	1 10 2	115/			
	Registra	r	31. Date filed (Month, Day 2010	32. Registrar's Signatur	Mad								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ye. 6:07A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 804 Cottonwood Drive Severna Park 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 Months Days Hours Min (Month, Day, Ye 406-38-0256 Director 78 Ohio Nov. Usual Residence of Decedent show or 28a-f show notified at 10a, State 10c. City, Town or Location 10d. Inside Cify Limits with the Maryland Director Severna Park MD Anne Arundel 1 Yes 2 X No 10e, Street and Number 10f. Zip Code ç 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21146 United States 804 Cottonwood Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2X No Black. White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Anne Arundel County (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Teacher School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rosalee Carter William Hover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Cottonwood Drive, Severna Park, MD 21146 Manvel Geyer / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 11/19/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 22. Name and Address of Facility Cremation Society of Marylan Signature of Funeral Service Licensee Alyson K Taylor <u> 299 Frederick Rd., Baltimore, Maryland</u> 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between et and Death Immediate Cause (Final Ph_sician/ disease or condition 4201 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for selection of annihilation Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No tate has been signed by the atte page 2 should be detached for i Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No မ 1 🗌 Yes 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Funeral I Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death accurred at the cause (s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 210 Annapla MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 45 ROP Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore** 4025 Boarman Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours (Month, Day, Y Apr 13, Year) , **1923** Maryland **Director** 87 218-18-7839 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 ☐ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21215 U.S.A 4025 Boarman Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Black If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Washington Lumber Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Alberta Hall Herbert W. Hall Sr. permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5708 Furnace Avenue Elkridge, Maryland 21075 Betty Cofield 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Lansdowne, Maryland 11/22/10 4 Donation 5 Other (Specify) Mt. Zion Cemetery Funeral Servige Licenses Signatu 22. Name and Address of Facility Estep Brothers Funeral Service, P. 300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Yes 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ❤️ No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of . 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes death. 2 🗌 No ☐ Accident
☐ Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of pe cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signature

NOV 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13 2010 Physician/ Joann Hall Medical Novem 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayview HOP RINS Medical Center Baltimore Security Number If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Date of Birth (Month, Day, Year)

5-31-1964 1 - M 2XXF Months Davs Director 46 MD 218-94-9624 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD na Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 4918 Greencrest Road 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. Specify: Black 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lorien Riverside Nurse Assistant 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester J. Jordon, Sr Mary E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hall-Husband 4918 Greencrest Road Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-19-10 March Trinity Cemetery ! LBaltρ, MD 22. Name and Address of Facility March 1101 E. North Avenue 21. Signature of Funeral Service Licensee Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons t and Death Immediate Cause (Final Pnysician/ Subarachnoid disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Malformation Arteriorenous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Increased Intracrania that initiated events resulting in death) Last anding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ☐ Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. Yes 2 2 🗌 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗋 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title RES-000

State Registrar 4940

Eastern Avenue, Baltimore MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10c, perFH, G909, 11/23/2010, WS
State of Maryland Department of Health and Mental Hygiene
ad Items 10b,c,d,25,27,28a-f. per me/fh, g909,11/19/2010dhb
Reg, No. | | | Amend Items Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** PM Sybil Hanna 16.38 30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A Medical Center Baltimore Johns Hopkins Bayview 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN . 2 , 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 1924 NORTH CAROLINA JAN. 86 Director 244-22-7275 Usual Residence of Decedent 10c. City, Town or Location

Eastpoint should be filed within 72 hours after death with the Marvland 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Ne Scall Evanting on the Design **Baltimore** 1-Yes 2 No **Funeral Director** BALTIMORE Dundalk MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 21224 7328 BERKSHIRE RD. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH OWN HOME 0 HOMEMAKER Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GINNY SMITH ALBERT B. WILLIAMS ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7328 BERKSHIRE RD., BALTIMORE, MARYLAND 21224 KATHLEEN FIELDS/DAUGHTER permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GLEN BURNIE, MARYLAND ATLANTIC CREMATORY 11/2/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Inter the disease, or communications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chie (Final **Physician** Hemorrhage Intracranial days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner THE CATTON APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Etc. Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 □ No Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred **Subject fell** 28c. Injury at Work? 5 Pending 2 X Accident 1 ☐ Yes 2 XNo Unknown M 10/27/2010 investigation down stairs 24 hours after deatl 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7328 Berkshire Rd. Eastpoint, MD determined 4 ☐ Homicide Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Opos T5591 October 30,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern C. Rory Goodwin, MD Baltimore, MD 21224 Avenue 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			Please Type or Pr Amend Item 2 per dyr	int in Black Indelible Ink, Ensure A /dr, 8909,11/22/2010dhb /aryk666/1197139726716618 ealth and M	II Copies	Are Legible.	
			1 - State Amend Item 27 per dr Registrar	Certificate of Death		eg. No.	36374
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h 11/10/2010 Day Year	
-	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Hovem	4c. County of Deat	8:27 PM
لممريد	LXaIIIII		Johns Hopkins Bayview M		2	40. County of Deal	
	Funeral Director		5. Social Security Number 1	ge (In yrs. last birthday) North Property of the property of	8. Date of Birth (Month, Day,		thplace (State or Foreign untry)
	faryland 8a-f show tifled at	Director	10a. State 10b. County Ra Himore	10c, City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 🕱No
	with the N 23a or 28 ust be not	Funeral Dir	10e. Street and Number 7801 Peninsula Expression	Apt. 304 10f. Zip Code 2/222	1	0g. Citizen of What Co	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infortant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Formula 1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 hou giene. ier than "natu ;, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Offetena Engineer	ng	16b. Kind of Business Towson Ur	• 4
	d be filed w Aental Hygi Irked othe Itic event, i	To Be	17. Father's Name (First, Middle, Last) Willie James Routhac	18. Mother's Name Audrey La			7.101311 y
	and 2 should Health and N em 27 is ma ther trauma		19a. Informant's Name/Relationship (Type, Print) Edith Green Daughter	19b. Mailing Address (Street and Number of Rural 903 Relgian Avenue	l Route Number,	City or Town, State, Zip	
nore	age 1 and out of Heal tr. If item ?		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
3altin	permit. Page 1 Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Fun → I Service I → ensee	1 rinity (emeter 1116) 2. Name and Address of Facility	(49	Kallimore, 05 york, F	cad
	40 2 6 0	_	23a. Part 1. Enter the disease, or complications that cause	ed the death. Do not enter the mode of dying, such as cardiac or	r respiratory arre	altindore, Mo	Ingland 21212
P	hysician/	0 9	shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition	+ Failure			Interval Between Onset and Death
	[⊱] Medical Examiner		resulting in death) a. Due to (or as	s a consequence of):			24 hrs
	p #	Examiner	cause. Enter Underlying	s a consequence of):	•		
			Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as	onary Artery Disease	<u> </u>		30 years
	ate be e hysicia the buri	dical	d				
Box 68760	n certinca tending p r use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome	e of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of del	
. Bo	he deat y the at ched fo	hysici	1 ☐ Yes 2 ☒ No	at time of death 5 Other (specify)		Month	Day Year
P.0	s that u gned by	þ	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.		acco use contribute to	
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<u>;</u>	Fnysic this or	유	1 ☐ Yes 2 ☒No Hospital: 1 ☒ Inpat 27. Manner of Death 28a. Date of inj	ogl- There is		nce 6 Other (Speci	ify)
o uo	ath. r: After	icate	1 X Natural 5 ☐ Pending (Month, Dispersion of the Control of the		28a. Describe nov	w injury occurred	
Division of Vital Records, P.O.		al Certificate:	building, et	tc. (Specify)	City or Town,		
-	the nospo	Medical	(Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☐ Certifying Nurse Practioner: To the	f my knowledge, death occured at the time, date and place, and examination and/or investigation, in my opinion, death occurred at t e best of my knowledge, death occurred at the time, date and place	the time, date and	place, and due to the o	cause(s) and manner stated.
			29b. Signature and title of certifier M. Kata Elfanz D. C	29c. License number RFS ~ (YC)	25	od. Date signed (Month	n, Day, Year)
	5)		30. Name and address of person who completed cause of		11	o de la companya della companya della companya de la companya della companya dell	0.0011
	Stat	<u> </u>	M. Kate Elfvey D.O. 494 31. Date filed (Month, Day, Year) 32. Registr	O Eastern Avenue Ba	Utm67	re, MD	21227
	Registra	•	101 1 0 2010 Brans	. A. pare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:26 AM Hagans Yovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Regional _aurel Hospita Laure George's If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Days Hours Min (Month, Dav. Year 5-40-197 **Director** September 21, 1934 Usual Residence of Decedent Fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 No trince aure 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1702 Montague 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. If Yes, Give **bcK** 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Prince Georges County Schools Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Smith Ir. Glad Beale dward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sypher Road California Emily Smith Lewis Sister Maryland 20619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ò Burial 2 ☐ Cremation 3 ☐ Removal from State 26 2010 ovington, Virginia injury Hill Cemetery ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any 2605 South Shirlington Read Arlington, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician neumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \square No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Place of Death (Check only one) Hospital: |은 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? X Natural injury 5 Pending 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weisman

31. Date filed (Month, Day, Year,

NOV

MD

D0067662

tem 23a) (Type, Print) 7300 Van Dusen Rd. aurel Regional Hospital, Emerg

November 17, 2010

MD 20707

Laurel,

Emergency

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

imothy Hill		1- For State Registrar	tate of Maryla		tment of <i>ificate of</i>	Health and M <i>Death</i>	lental Hy	_	g. No. 2010	36376
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd Timothy Hil	•				2	2. Date of Death Month November		3. Time of Death 1710 hrs
		4a. Facility Name (if not instituti	on, give street and nur	mber)	4	b. City, Town, or Locat	tion of Death	November	4c. County of Deat	λ
Funeral		Good Samatrian Hos 5. Social Security Number		7. Age (In yrs. las	st birthday)	Baltimore If Under 1 Year If I	Under 24Hrs.	8. Date of Birth	n(MM/DD/YYYY) 9. Bi	
Director		unk	12 M 2 F	52	Yrs.	Months Days H	lours Min.	3/27/	58 Forei	ountry) MD
any		Usual Residence of Decedent 10a. State 10b. County			own or Location					10d. Inside City Limits
land fand -f show	tor	MD N/	Α	Balt	imore					1X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	I Director	10e. Street and Number 1620 Pentwoo	d Rd			10f. Zip Code 21239		10	g. Citizen of What Cou USA	intry?
5 .~님	Funeral	11. Manital Status 1 Never Married 2 N 3 Widowed 4 Di		2 🔀 No	If Ye	Decedent of Hispanic es, specify Cuban, Mex	rican, Puerto R		14. Race - Amer White, etc. Africa SpecifyAmen	
hours af	ed by	15. Decedent's Education (Spe	l or Dates: ecify only highest grad	e completed)	16a. Decedent	's Usual Occupation (G	Sive kind of wo	d)	16b. Kind of Business	
0036 within 72 liene. er than "y Medical E	Completed by	Elementary/Secondary (0-12)		4 or 5+)	_	re Provi	der		Hospital	
215-(De filed vertal Hygicked of the orth	Be C	17. Father's Name (First, Middle Robert Hill,							aiden Surname) Wrence	
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica	2	19a. Informant's Name/Relations Mary Allen/S				Address (Street and Pentwood			per, City or Town, State	e, Zip Code)
IOFE, Neges I and to of Healt is: If item other trau		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 11/20/10							20c. Location - City or Balt., MI	Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service		110				- 1	lose F.Sv MD 21206-	
Physician	\dashv	23a. Part I. Enter the disease, or failure. List only one cause		used the death. D						Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Narco	otic into	oxicati	on				Death
	إ	Sequentially list conditions,	b							
	Examiner	if any, leading to immediate rause. Friter Underlying Causa (Disease or injury that initiated	C	consequence of):						
cuted and transit		events resulting in death) Last	dd.	consequence of):						
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687(certifical	-	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 1 Live bir	th int at time of death	2 Feta		topic pregnanc		23d. Date of deliver Month	y Day Year
C. t. ya		Part II. Other significant condi	9 Unknow		ulting in the ur	iderlying cause given in	n Part I.	23e. Did tob	acco use contribute to	the cause of death?
S, P.O.	Completed by								2 No 3 Prol	,
of Vital Records, Pag Physician: The law requires Wher this certificate has been sign neral director, page 2 should be	mplet							24a. Was ar autopsy perform	y prior to one death?	topsy findings available completion of cause of
ital Recician: The sectorificate		25. Was case referred to medica	ıl T			26.Place of De	eath (Check onl	1 Yes 2 ly one)	No 1 Y	es 2 No
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on of anding Ph uth. r: After t		27. Manner of Death 1 Natural 5 Pen	28a. Date o (Month, I		8b. Time of In	1 Vec 2		8d. Describe ho $\mathfrak{n} k$	ow injury occurred	
Division ppital or Attendia cours after death. neral Director: A	Certification:	3 Suicide 6 X Cou	28e. Place		e, farm, street	pıq , factory, office building ı Hospital		or Town, Sta	te) 5601 Loc	ral Route Number, City h Raven Blv
		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge,	, death occurre	ed at the time, date and	d place, and du		(s) and manner as stat	
To the within To the comple	Medical	29b. Signature and title of certific	and manner sta	ated.		29c. License numl			29d. Date signed (Mo	
		Therelow -	m. 7. :	70	3	O.C.M.E.	OCME		November 15, 20	
	ļ	30. Name and address of persor Theodore M. King, Jr.		of death (Item 23 nt Medical Exa	,	I I11 Penn Street,	Baltimore	MD 21201		
Sta	2	31. Date filed (Month, Day, Year)		istrar's Signature		1				
Registr	ar	NOV 192	MI SHARW	a p.	14 19 19 18 ST					

State Registrar DHMH 17 Rev 7/2009 D 0065485

1500 Forest Glen Rd Silver Spring MD 20910

Supanich, RSM ND

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Supanich MD

9 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5ther of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 0102 Robert Edmond Haynes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore VA Hospital Baltimore 5. Social Security Num 553 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 1 DM 2 □ F Months Hours 097727277929 W.Virginia 579-32-7554 81 Yrs Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3232 Tioga PKWY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Armed Forces?

No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yoo Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other that any injury or other traumatic event, the Nores. Self years Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Margaret D. Jackson Rev. Dr. E. Adolph Haynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3232 Tioga PKWY, Baltimore, MD 21215 Marion Haynes(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Josephembrowhrh And Crematory ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 11/17/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 303ephodes of Brown Jr. Funeral Home PA 21217 2140 N. Fulton Ave., Baltimore, MD lamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ months Osteomuelitis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defected for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? has this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗀 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 106373751 11/12/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ON. Greene Ciccotto Baltimore, MD 2120 Sarah

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's signature

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Medical Exam				Month November	Day Year	0757 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Deati	1
1		5288 Pulaski Highway	Perryville		Cecil	
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			th(MM/DD/YYYY) 9. Bir Foreid	thplace (State or
Director			Yrs.	05/23		untry) MD
9 any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
C/ A.		MD Nonthand				1 Yes 2 N
732 Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Cou	
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r death or ite must	E	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	
s after ral", niner	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		Specify: Wh:	
2 hour "natt	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation (Give kind of most of working life. DO NOT use re	f work done etired)	16b. Kind of Business/I	ndustry
336 thin 7 re. than	檀	Elec	trician		Commercia	
5-0 led wi tygies other	් දි			ne (First, Middle, M	Electr: Maiden Surname)	LC
21215-0036 Mold be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "matural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Be		Marily	n Prath	ner	
M 3 4 # 0	ြင		ing Address (Street and Number or			, Zip Code)
Baltimore, MD bernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is niury or other traumati			Tulip Dr. Conc	owingo,		
nore ages 1; nt of H ht: If it		1 Burial 2 Cremation 3 Removal from State crematory or	other place) NC	v. 19,	20c. Location - City or	
Itim it. Pa rtmen rtmnt		4 Donation 5 Other Specify: Chesape 21. Signature of Funeral Service, Licensee	ake Crom 2	2010	Deresviri	
Baltimo permit. Page Department or Important:		10 N MUIS 851	. Name and Address of Facility AF	'A/Steph	nen D.Lohr	mann P.A
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/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone intoxicat				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				-
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si g	Examiner	events resulting in death) Last Due to (or as a consequence of):				-
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OX (eath ce attend for use	sici	4 Pregnant at time of death 5	Other (Specify)			
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by ted in by the finneral director, page 2 should be detacted.	ð	Salar Sa	underlying cause given in Fait i.		2 No 3 Proba	
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e law e has l	립			autops:	y prior to co	mpletion of cause of
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ivision or Attencath after death Director: d in by the	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, str	et, factory, office building, etc.	28f. Location (Str	reet and Number or Rura he Perryville Perryville	al Route Number, City
Di ospital hours a nneral I	3	4 Homicide determined (Specify) found in mo				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investign	irred at the time, date and place, and ation, in my opinion, death occurred:	due to the cause	s) and manner as stated	i.
To To con	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
		The I was I am	O.C.M.E. OOM		November 9, 2010	
E O	-	30. Name and address of person who completed carse of death (I/em 23a)	1		-, -3.	
Per		Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimore	e, MD 21201		
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signifiure				
Regist	tel.	MAN TO COLO (TOWN) B. MANOR				

Registrar DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State State Registrar State Amend Items 25,	of Marylan 27,28a-f	nd / Depa per	rtment of H	ealth and /19/201 eath	Mental Hy 0dhb, 26,	giene per dr	36380
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Funera		Sinai Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	Baltim If Under 1 Year	If Under 24 Hrs.		h NA	Birthplace (State or Foreign
Directo	_	214-20-1945 1 M 2X F	8.5	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year) 1-2-5	Country) MD
and show	ě	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
Mary 28a-f	Director	MD NA	Ва	altimo					XXYes 2 □ No
vith the 23a or st be r	al	10e. Street and Number 4202 Maine Avenue			10f. Zip Code 212	0.7		10g. Citizen of What USA	Country?
death v items	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S		as Decedent of His Yes, specify Cuban	panic Origin? (Sr	pecify Yes or No-	14. Race - Ai	merican Indian,
after al", or xamin	d by	If Yes, G			Yes 2 No		o ricaii, etc.)		hite, etc. African nerican
21215-0036 within 72 hours after glene. ler than "natural", o ler than Medical Exam	Completed	15. Decedent's Education (Specify only highest grade complete		16a. Deced	ent's Usual Occupat	tion	lian	16b. Kind of Busine	
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nd 2	Be	8th Grade NA 17. Father's Name (First, Middle, Last)		1 10011		18. Mother's Nar	ne (First, Middle,	Maiden Surname)	Company
ylar uld be Ments narked	2	John Frank Jones,	Jr.			Emili		Porter	
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)							Zip Code)21202
of Heal fitem		Cassandra Lucas-Gu 20a. Method of Disposition	20b. P	lace of Dispos			Date Date	1.F1. Suj 20c. Location - City	
Baltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or other		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)			on Cem.	11-	16-10	Lansdown	,
Baltimo permit. Page Department of Important: If		21. Signature of Funeral Service License	<u></u>		Name and Address 38 N. G	of Facility W	ylie Fu Street	neral Ho Baltimor	ome P.A. e,MD 21217
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a	t caused the death						Approximate Interval Between
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Box death of atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pre	e Birth 2 Feta gnant at time of d		Ectopic pregnancy Other (specify)			23d. Date of a	Day Year
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Division of Vital R lal or Attending Physician: Th s after death, al Director, After this certificate ed in by the funeral director, pa		27. Manner of Death 28a. Dat		28b. Time of	28c. Injury a	at	28d. Describe ho	ow injury occurred St	ubject choked
Sior Attend r death ector; A	Certificate:	3 Suicide 6 Could not be	e of Injury - At hor ding, etc. (Specify)	8:10 a		es 2 🗴 No			
Divi		Ass	isted Li	iving F	acility		Baltimo	re, MD	Gyral Route Number, St.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check (Check chly cha)) 2 Medical Examiner: On the back chly cha) 3 Gertifying Nurse Pranticon	asis of examination	and/or investig	ation, in my opinion,	death occurred a	at the time, date ar	nd place, and due to th	e cause(s) and manner stated.
within to the complete of the		29b. Signature and title of confifier	h h	2	29c. License n			29d. Date signed (Mor	
	Va.s	30. Name and address of person who completed cau	ise of death (Item	23a) /Ti/pa Pri		254	7	11/9	110
		S MUSEL 1	000	CAT	THE DOZA	th 31	- BA	4L71MOR	E,MD 2120
St. Regist	ate rar	31. Date filed (Month, Day, Year) 32	egistrar's Signati	8 . A.	my think				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day 14,2010 Physician/ Helen Geraldine Joyner 3:00 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7838 Westmoreland Avenue Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | Oct. 22, 1923 Social Security Number **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Mary Iand 216-16-5118 **Director** 87 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Parkville MD Baltimore 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7838 Westmoreland Avenue 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 3 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. '' is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Noetzel Henry Greenlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
731 Fairwind Drive-Bel Air, Maryland 21014 Edward Joyner-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other plac Garrison Forest VA Burial 2 Cremation 3 Removal from State Nov.23,2010 Garrison, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services ondrai L. ME 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final MALIGNANT TUMOR, MANDIBLE Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner REMOTE CIGARATE USE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in literal and the cause (Disease or linjury) Examine Due to for as a conswauence of The law requires that the death certificate be executed attending physician and for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at a be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPGETENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should HYPGRUPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CORDINY ARTERY DISONSE CEREBROVAS CULAR DISEASE 2 N 1 Yes 2 🗌 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 ☐ Yes 2 ☐ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Accident Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month. Day, Year) 15, D 25010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERENA R. NOUND MA 8831 SATYR HIM AD A LOO BALTIMONS MO 21234 31. Date filed (Month, Day, Year 32. Registrar's Signature State NOV 1 9 2010

DHMH 17 Rev 7/2009

Registrar

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10-08317 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Linwood Earl King State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 31, 2010 Linwood King **Medical Examiner** Earl 1035 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1300 East Lanvale Street Apt 806 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign **Funeral** March 26,201 231-08-4332 Director Days Min Months Hours 41 1 X M 2 F Virginia Usual Residence of Decedent 'n 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show notified at once, Maryland Baltimore 1 X Yes 2 No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injurity or other traumatic event, the Medical Expulser, must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 East Lanvale St., #806 United States 21201 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married 2 X No Yes Specify: Black 3 44 Widowed 1 Yes 2 No specify: Divorced If Yes, Give Year ₫ 15. Decedent's Education (Specify only highest grade completed) Toa. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Retail Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Haskins King Be Gloria Joyner 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria King (Mother) 1160 Clydesdale Lane VA, Beach 23464 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Princess Ann Memorial Nov. 13,2010 Norfolk, VA Donation 5 Other Specify Vice Licenses 21. Signature of Euner 22 Name and Address of Facility
Carlos A. Howard Funeral Home 436 W. 35th St., Norfolk, VA 23a Part I. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Seizures Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Prior Meningitis Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed vsician/Medical 8 & 11, per Inf g910 12/17/10 TT X AMENDED 0α 11, P UNPENDED attending physician or use as the burial PII,27, per ME g909 11/30/10 TT Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Live birth Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ₫ 23e. Did tobacco use contribute to the cause of death? ģ alcohol use 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been I director nave 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy раке ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes No After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2

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31. Date filed (Month, Day, Year) State NOV 19 2010 Registrar

29b. Signature and title of certifie

Victor Weedn MD JD

32. Registrar's Signature

and manner stated

el

Assistant Medical Examiner

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

November 1, 2010

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Wovem Physician/ Carlton A. Keys Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ville HINOTE 2N0 MW O- Birthplace (State or Foreign Country) If Under If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 1 Year 5. Social Security Numbe **Funeral** 1 🙀 M 2 🗆 F Months Hours Min 06/03/1924 Yrs. 579-20-2590 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10h County ral", or items 23a or 28a-f shore Examiner must be notified at Director 1 🗌 Yes 2 🙀 No Catonsville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21228 719 Maiden Choice Lane HR429 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural". Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. FAA Federal Govt Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Olive M. Jenkins Albert Kloczewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3943 Bayside Drive, Edgewater, MD_21037 Daniel T. Keys (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Crownsville, MD 11/23/2010 Vets-Crownsville Signature of Funeral Service Lidensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Avenue, Baltimore, Mary 4107 Wilkens Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ 'o Ke Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 filled in by the funeral director, page 2 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an person who completed cause of death (Item 23a) (Type, Print) 15+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36384 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WOONTH BEA WILLTAM KEITHLEY 37 Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death umma BALTEMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1 ★ M 2 □ F Months Hours Min. (Month, Day Year) 1947 Mary Land 212-50-7026 Director 63 Usual Residence of Decedent items 23a or 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3921 Longley Ct. 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 No 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Engineering Technician U.S. Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Inportant: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve ည Adam James Keithley Mabel Grace Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Keithley / Wife 3921 Longley Ct., Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 F from State Denation 5 Other (Specify Highview Memorial Gdn 11-22-10 Fallston, Maryland 21. Signature of Fune McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Drawt and Death Physician/ SEFTEC disease or condition resulting in death) SHOCK Medical Due to (or as a consequence of Examiner DAYS SCHERICHIA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No neral Director; A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined City or Town, State) hin 24 hours a the Funeral E mpleted filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 1386969327 DAVED 2010 WACKER erson who completed cause of death (Item 23a) (Type, Print) BALTEMORE FREENE STREET

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month,

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32. Registrar

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. amend #29d PerFh G909 11/19/10 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV^{Month} Physician/ Samue 1 2010 David Kruh 1:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sex 1X M 2 □ F **Funeral** Country) W York July 9, 1920 Months Davs Hours Min. 082-12-9771 90 **Director** New Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Howard Columbia 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be ? Funeral 5717-C Harpers Farm Road 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married þ 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WW II Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Advertising Designer Advertising permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Joseph Kruh Sadie Bodkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hillary E. Kruh, daughter 312 Oakdale Road Baltimore, MD21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/16/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD Inc. EMA 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph sician/ menn disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 use as the phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 1200 1 🖵 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performe 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causes.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
November 16, 2010 29b. Signature and title of certifier 29c. Lie

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AW) N (ALAWES W) (70

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11^{Mo}T^t5-2016^{ay} Physician/ 715 P M Helen D. Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Autumn Assisted Living Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Min. Months Days Hours 89 04-03-1921 MD 218-07-8081 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Harford Churchville 1 ☐ Yes 2 🛣 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 21028 USA 3049 Oak Farm Rd permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner.mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Force 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 XWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dress Factory Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Szydowska 2 Constantine Filipowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3049 Oak Farm Rd Churchville, MD 21028 (Daughter) Diane Niemeyer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1
Burial 2
Cremation 3
Removal from State 11-17-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature Service Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 7 con Medical Due to (or a a consequence of): Examiner Gequentially rist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated parts) Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death s been signed by the s should be detached 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerformed death? within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 - WING 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ovemb o completed cause of death (Item 23a) (Type, Print) 21040 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36387 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13 2010 James Joseph Lyons November 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Renaissance Catonsville Baltimore 5. Social Security Number Sex 1X M 2□ F 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 91 Director 130-01-9598 10/17/1919 New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examinating be notified at Director MD Baltimore 1 ☐ Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 715 Maiden Choice Lane CC515 Funeral 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 1 ☐ Yes 2 ☐ No Specify. þ White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Purchasing Agent</u> Chemical Manufacturing mportant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Daniel Lyons Theresa Allen ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary T. Lyons (Spouse) 715 Maiden Choice Lane CC515, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4☐ Sonation 5 ☐ Other (Specify) 11/19/2010 | Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Processes 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Du to (o s a conse ve ce of): Neek5 /Medical Examiner erebral vascular disease Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tra Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Alzhaimers Completed ASCVD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 □ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death 2 Accident investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only

The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: 124 hour. completely within 2

21215-0036

Baltimore, Maryland

.Tames

State Registrar DHMH 17 Rev 1/2001

711 Maiden Choice In Cadonsville MD MD Corporter

ress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

D30989

29d. Date signed (Month, Day, Year)

November 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Manth / 10 /2010 J. Leonard 7:35a M Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Cheverly Examiner 4c. County of Death P.G. Hospital P.G. If Under 1 Year If Under 24 Hrs.

Davis Hours Min. Social Security Number 7. Age (In yrs. last birthday) 84 vrs 8. Date of Birth (Month, Day, Year) 4 / 1 1 / 1 9 2 6 Birthplace (State or Foreign Country) **Funeral** 237-22-9874 1 M 2 X F Director **17**Δ Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Gaithersburg Montgomery 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? Funeral 763 Owince Orchard Blvd 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc Page 1 and 2 should be filed within 72 hours after do ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or it þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Dunsinane Court Silver Spring MD 20906 Linda E. Leonard Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite Atlantic Crem 1 Burial 2X Cremation 3 Removal from State 11/12/10 Glen Bernie MD injury (4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Simplicity Crem&Fun Service 7090 Ridge Rd Hanover MD ThomasAllenPA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) bacterenia Medical Due to (or as a consequence of): Examiner mumothors Sequentially list conditions. Examine if any, leading to immediate Die to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant Month Year Day Pregnant at time of death Other (specify) cate has been signed by the a page 2 should be detached in 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 24 hours after death.

Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chevely, MO Lagunas-Fith

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

NOV

Hospital

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 513 PM <u> Annie Mae Catherine Carter McQuay</u> NOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 M F Oct. 9, 1939 Hours Min. Mary land Director 219-26-5447 71 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ▼ Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 924 North Fulton Avenue Apt. B 21217 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Assembly Line Worker A & P Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mabel Classes Eggleston John Carter, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Heathfield Road Baltimore, Maryland 21239 <u> Camelia Doretha Allen — Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/23/2010 Arbutus Memorial Park Arbutus, Maryland Signature of Funeral Service Livensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ gasto in test mal disease or condition resulting in death) 2 weeks Medical Due to (or as a consequence of): Examiner 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the last of the cause) Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Tes within 24 hours after death.

To the Funeral Director: A 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State
Registrar

DHMH 17 Rev 7/2009

UNIVERSIT

PKWY

BALTIMORE,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

32. Registrar's Signature

MD

KALARIA

31. Date filed (Month, Day, Year)

NEHA

11-13-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36390 Certificate of Death Reg. No: 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year George W. Moaney 4=15AM Jovenber 172010 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number N/A timore aton Manor >a chesis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 X M 2 □ F Yrs Maryland Aug 17, 1923 216-20-6192 87 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 1631 Ruxton Avenue 21216 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify Black Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) C & P Telephone Company Elementary/Secondary (0-12) College (1-4or 5+) Custodian 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Moaney James Moaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Ruxton Avenue Baltimore, Maryland 21216 Ernestine Moaney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/24/10 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fanor I Service Licensee Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ROSTA GWYRS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

The law requires that the death certificate be executed ng physician and as the burial-tran Division or Vital Records, P.O. Box 68760, attending properties for use as certificate has been signed by the rector, page 2 should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

**/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Examine

Physician/Medical

Completed by

Be ို

Certification:

Medical

29a. Certifier

(Check only

Funeral

Director

show

if item 27 is marked other than "natural", or items 23a or 28a-f si or other traumatic event, the Medical Examiner must be notified

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event the and injury or other traumatic event the and

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Seerge

CVA, Go	LUN CANCER	, 115	PRE	33102		1 ☐ Yes 2 ☑	No 3 Probably 4 Unknown			
						24a. Was an autopsy performed? 1□ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Nursing Hon	ome 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M		Injury at Work? 1 ☐ Yes 2		28d. Describe how injury	occurred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa fy)	ctory, of	28f. Location (Street and Number or Rural Route Number, City or Town, State)						

one) 29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

> MD Doo 62634

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Nov 18, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COLUMBIA MO 2/044 HIKKERY RIDGE MATERN 10796 AWAN

State Registrar 31. Date filed (Month, Day, Year) NOV 1 9 2010

			For State	State of Ma	aryland /		rtment of F		d Mental		2010	36391
			Registrar 1. Decedent's Name (First, Middle, La	act)		Cei		Jeani	2 Date	Reg.	No. U I U	3. Time of Death
	Physic	an		,					Mont	h	Day Year	
	/Medi		Aletha E. Mau 4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of De	Nov		5 2010 4c. County of Death	9:20 AM
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	Funeral		Genesis Health 5. Social Security Number 6.		ne Pin		If Under 1 Year	aston If Under 24 F	Irs. 8. Date	of Birth	9 Birth	place (State or Foreign
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	D .		Usual Residence of Decedent									
	ırylar show	Ļ	10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	e Ma	cto	Maryland Talbot		Eastor	1						1 □Yes 2 No
	ift t	Ö	10e. Street and Number				10f. Zip Code				Citizen of What Cou	intry?
	death with the Maryland	Funeral Director	610 Dutchsman La	T			21601				S.A.	
	er de	nu.	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Ye s erto Rican, et	or No- c.)	14. Race - Amer Black, White	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □Yes 2 ▼ N If Yes, Give Year or Dates:	10	1	□Yes 2∏ No	Specify:			Specify: Wh	ite
8	hour ttural	ed	15. Decedent's E		16	a Deced	ent's Usual Occup	ation		16h	b. Kind of Business/li	
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er	filed II Hyg othe	Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's N	lame (First, M	liddle, Maid	den Surname)	
urei	uld be Aenta rked tic ev	To E	William Patchen					Ella M	ae Hal	1		
Maurer Maryland 21215-0036	shot and N s ma		19a. Informant's Name/Relationship	(Type. Print)	19	b. Mailin	g Address (Street a	and Number or	Rural Route i	Vumber, Ci	ity or Town, State, Z	ip Code)
	and 2		John N. Kirk (S	on)	3	3512	Choptank	Rd., F	reston	, MD	21655	
Aletha altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evan has a natified at once.		20a. Method of Disposition	7	20b. Place cemet	of Dispos	ition (Name of atory or other plac	e)	Date	200	. Location - City or T	own, State
<u>n</u> et	Page nent ant: It		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				e Cremat		19/201	0 Wa	terville,	NY
A] alti	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	nule /	,	22.	Name and Addres	s of Facility	owal D	omo		
Ω	8 3 E 8 8		* Lecuni	Mounn		41	Name and Address Inn & Har 8 N. Geo	rge St.	, Rome	, NY	13440	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Adu		Mun	e foti	mile			1	Onset and Death
	/Medical		resulting in death)	Due to (or as a			15					/
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	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	70775C	mar	MSUT	ficten	(4)			years
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Вох	atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	/			23d. Date of deli- Month	Day Year
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₽.	that ned b		Part II. Other significant conditions	contributing to death bu	it not resulting	in the un	derlying cause give	en in Part I.	23e.	Did tobac	co use contribute to	the cause of death?
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æ	The fare te ha	崩		***					- _	autopsy performed	prior to c death?	ompletion of cause of
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<u> </u>	yslci is cer direct	20	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	nt 2 □ ER/C	Outpatient	3 □ DOA Othe	r: \/			e 6 □Other (Spec	eifu)
o	ding Physician: The P.n. h. After this certificate ha funeral director, page	盲	27. Manner of Death	28a. Date of Injur (Month, Day	v 28b.	Time of Injury	28c. Injury				njury occurred	
į.	ath. rr: Af re fur	atio	1 Natural 5 Pending 2 Accident investigation		, rear)	injury		Yes 2 □ No				
Division	r Atte er de recto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, t	farm, stre	et, factory, office		28f. Loca	tion (Stree or Town, S	t and Number or Ru	ral Route Number,
	tal on rs aft al Di al Di led in	Se							V.		,	
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. within 24 hours after death. within 24 hours after death. To the Funeatal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	cal	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	of my knowledge examination a	ge, death and/or inv	occurred at the tir	ne, date and pl pinion, death o	ace, and due	to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
	the hin 2, the F	Medical	one)	and manner sta								
	5 V V V		29b. Signature and title of Cartifle	10/			29c. Licenso	e number	7	29d.	Date signed (Month	, Day, Year)
			11000				TIL	7777			//'/-	110
1			30. Name and address of person who	completed cause of de	010	(Type, F	Print)	ie In.	1.2 1.	Burn	an mn	21661
,	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature) D	UTCHIA11	V> HIT	VC F	177	UN, 1-10	01001
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 State of Maryland / Department Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Haze1 Maddox Physician/ Month 12 Maddox 20T0 Helen 2:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** na Balto <u>6213 Northwood Drive</u> If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. (Month, Day, Year) 2-8-1948 214-50-2083 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD na 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 21212 USA 6213 Northwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Public School Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Masters 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Bessie Robinson Alexander Colvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21212 6213 Northwood Drive Daniel Maddox-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State **Burial 2 Cremation 3 Removal from State 11-18-10 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 21. Signa Lire of Funeral Service Licenses March East F/H 22. Name and Address of Facility 1 21202 Balto, MD 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached a g Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 24 hours after death.

Funeral Director: After this leted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completed f (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 2010 inpleted cause of death (Item 23a) (Type, Print). Huy 65

DHMH 17 Rev 7/2009

State Registrar NOV 1 9 20

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 36393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1109 AM Dovembe Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Northwest Hospital If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Country 1 🔀 M 2 🗆 F Days Hours Min (Month, Day, Year) 238-11-7046 53 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1 XYes 2 No Baltimore MD na 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21202 USA 1117 Wilmont Ct "natural", or items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. other traumatic event, the Medical Examiner Black, White, etc 1 Never Married 2 Married by Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Various Jobs 12th grade Labored Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked or မ should be Hazel Mae McKoy Senis Thomas, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, MD 21202 1117 Wilmont Ct Francine McKoy-Wife item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot cemetery, crematory or other place, ☐ Burial 2XXCremation 3 ☐ Removal from State 11-20-10 Balto, MD Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1117 Wilmont Ct Balto, MD 21202 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End steer e disease or condition resulting in death) Medical Due to (or as a consultance of): Examiner per tension Sequentially list conditions, Examine Due to I s a consequence of cause. Enter Underlying igned by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lamor 1 Yes 2 No 3 Probably 4 Inknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No death? 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Jother (Specify) Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0053337

State Registrar 31. Date filed (Month, Day, Year) \(\) NOV 19 2010

Are Ste 203

Baltriere. Md 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 15:45 IVY MANGAL November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BELAIR HARFORD CO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Date of bill. (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Hours Director Yrs JAMAICA 217-11-4043 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MARYLAND HARFORD CO ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 463 MANOR RD. 21001 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceue... _ Armed Forces? ¹ ☐ Yes 2 ♣ No Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: INDIAN 3 XWidowed 4 □ Divorced Completed er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade HOUSEWIFE is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ Page 1 and 2 should be ment of Health and Ments BUDHOO BUDHOO K SUCKOO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 463 Manor Rd., Aberdeen, Maryland 21001 Rupert Mangal/Son Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MANGAL FAMILY PLOT 11-28-10 CLARENDON. JAMAICA 21. Signatule of Funeral Service COMM Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each lice. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to innicitate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine attending physician and for use as the burial-transit resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 힏 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Nurse Bractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

500 UPPER CHESAPEAKE DR.,

BELAIR, MD.,

CARLA JANSON,

31. Date filed (Month, Day, Year)

NOV

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G912 2/09/2011 JH Amend Item 20 are Maryland 10 per party 19/20 Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sophie Maroulis Μ. 2010 6:05 A M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville Baltimore 1919 Knollton Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye March 05 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours 1920 Greece Director 214-38-3515 90 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Tes 2 X No Baltimore Lutherville Md.10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral USA 21093 1919 Knollton Rd. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ð Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Clothing Seamstress 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) V1ahopoulos ည Despina Katimerozoglou Yianni **Vlahoglou** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trac Mrs. Irene Dzouropanos/ Dtr. 1919 Knollton Rd. Lutherville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Ortho. Cem. 11-16-10 Woodlawn, Md. 22. Name and Address of Facility RUCK Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fundamental Service Liv 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiration Ph sician/ disease or condition Medical resulting in death) Examiner tenste tral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy After this certificate has page 2 performed?

Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Investigation 24 hours after deatl Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 00050414 of Cure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Folls Ro, Lutherville, MO. 21097 12 10755 Noth WESTT 31. Date filed (Month, Day, Registrar's Signature State NOV 1 Q Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ľ	1 - For Amend Item Registrar	State of Ma	ryland dr.	, Depa , g909 , Cert	tment of l 1171972 ificate of L	dealth Death	and Mental I	Hygier Reg. 1	ne Na O O L	0 00000
	Physicia	n/	1. Decedent's Name (First, Middle, La	ast)					2. Date of	f Death	201	3. Time of Death
j)	Medic	al	Robert C. 4a. Facility Name (if not Institution, giv				4b. City, Town, o	r Location o	NOV.			
	Examir	er	2152 Firetho				•	lle R		ĺ	4c. County of D Balt	imore
	Funeral Director		219-40-1619	Sex 1 M 2 G F 7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 2 Hours		Birth , Day Year 15	1943	Birthplace (State or Foreign Country) MD
	and show	ě	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca						10d. Inside City Limits
	Maryla 28a-f	irect	MD Baltin	nore		Mid	dle Riv	er				1 ☐ Yes 2 X No
	with the is 23a or	Funeral Director	10e. Street and Number 2152 Firetho	orn Road			10f. Zip Code	2122	0	10g.	Citizen of What USA	
36	after deatl I", or iten xaminer n	β	11. Marital Status 1 □ Never Married 2★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give		lf Y	as Decedent of H /es, specify Cuba ☐ Yes 2 ☑ No	an, Mexican,	gin? (Specify Yes or , Puerto Rican, etc.)	No-	Black, W	
2-00	hours 'natura dical E	oletec	15. Decedent's		-7	16a. Decede	nt's Usual Occup	ation	:	16b.	Kind of Busine	White ss Industry
121	ithin 72 ene. r than " the Med	Completed	(Specify only highest g Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	nd of work done o NOT use retired) aborer	during most	of working		ommuni	ty College
nd 2	filed w al Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)	1yr		، سا	Dorer		r's Name (First, Mid	die, Maide	n Surname)	ey correde
ıryla	ould be id Meni marke matic	잍	Daniel Murphy 19a. Informant's Name/Relationship (406 14-10	A dalara a 10to a d		ecilia I			7. 0. 1)
, Ma	nd 2 sh ealth ar n 27 is ier trau		Connie Murphy	, ,		215	2 Firet	horn	r or Rural Route Nur Road Ba	alti	more M	D 21220
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menta Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 [4 🗀 Donation 5 🗆 Other (Spec		20b. Placent	ce of Disposi netery, crema dens	ion (Name of tory or other place of Fait	h	Date 11/16/10		Location - City ossvil	
Balt	permit. Depart Import any inj	8 0	21. Signat e of Funeral Service Licer	see Jewy		22. I	Name and Addres	ss of Facility 7 Fun	300 Mae eral Ho	ce A	ve. Ba f Esse	lto. MD x 21221
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused to one cause on eath line.	he death. I							Approximate Interval Between Onset and Death
4	Physician/ Medical		disease or condition resulting in death)	a. A NAV	consequen	LU/	JG CA	NUX	K			Onset and Death
	Examiner	er	Sequentially list conditions, if my like ling to immediate	b. Due to lor as a	conse wen	nce off:						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	C							7	
0	certificate be executed nding physician and use as the burial-transit	edical E	resulting in death) Last	Due to (or as a	consequen	ice of):						
8760	tificate ng phy s as the		IF FEMALE:	- u								
. Box 68	sician: The law requires that the death certific certifica e has been signed by the attending prector, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal d	eath 3 🔲 I	Ectopic pregnanc Other (specify)	_Б у		-	23d. Date of Month	delivery Day Year
(c s, P.o.	ires that the signed by do be detact		Part II. Other significant conditions	contributing to death but			lerlying cause giv					to the cause of death? Probably 4 Unknown
cords,	w equ	Completed by	WNG CANCE	2 (SECON			-		24a. W	/as an utopsy		autopsy findings available o completion of cause of
	ica e ha		DIABETES						l p	erformed?	death	
A Ital	ysician s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien	+ 2 N EB	2/Outpatient	Othe		rsing Home 5 🛣 R	ooldov	ath av (Ca	H COIGS
n of	nding Phy ith. t After thi funeral o		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day,	28	Bb. Time of injury	28c. Injury work	/ at	28d. Describ		ury occurred	echy)
Division	al or Atter s after des I Director d in by the	Certificate:	3 Suicide 6 Could not l	oe 280 Place of Injure		e, farm, street			28f. Locatio	n (Street a Town, Stai		Rural Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificale has completed filled in by the funeral director, p. ge 2	Medical	(Check 2 Medical Exam	rsician: To the best of m liner: On the basis of exa se Practioner: To the be	mination ar	nd/or investiga	ation, in my opinio	n, death occ	curred at the time, da	te and plac	ce, and due to th	e cause(s) and manner stated.
	To the within com,		29b. Signature and title of certifier P. LEVA+	ris MD			29c, License		(Date signed (Mo.	
	(10)		1 EDATTIC	completed cause of dea	th (Item 23	la) (Type, Prir	PA-UZ	PI	RAM	1Mr	DR N	ND 21200
9	Stat Registra	e	31. Date filed (Month, Day, Year) 201	0 \$2. Registrar's	Signature	par	1		, 40)	17 - 00	10	

			For State	State o	of Maryla		artment of H		Mental Hy	giene	011	26207
			Registrar 1. Decedent's Name (First, Middle,	ast)		Cer	tificate of L	Jeath	2, Date of De	Reg. No	110	30331
	Physicia			an)cul	ch				Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, o	r Location of Dea	th 2 Jen 1	4c. County	ر رو ر v of Death	(03)
	2,0	•	Simml Pa	-le				tonsvill			1timo	re
	Funeral		Social Security Number	. Sex 1 □XM 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th v. Year)	9. Birthp	place (State or Foreign
	Director		082-14-0833 Usual Residence of Decedent	T LANVI Z L T	88	Yrs.			Aug. 2	y, Year) 2,1922	Ne	w York
	and show	ō	10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Maryls 28a-f	Director	MD Balti	more			Catons	sville				1 🏋 Yes 2 □ No
	a or 2	Ē	10e. Street and Number		1		10f. Zip Code			10g. Citizen of	What Coun	ntry?
	sfiled within 72 hours after death with the Maryland tal Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	1502 Frederi					1228			ed St	
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21215-0036	s afte ral", o Exan	q pa	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e	1	☐ Yes 2XXXNo	Specify:		Specify	" Wh	ite
2-0	2 hour	plet	15. Decedent (Specify only highest				lent's Usual Occup		orkina	16b. Kind of B	usiness Inc	dustry
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Maryland		2	John	Manku1	ish			Elizab		waigen daman) Veh	ec
a٦	2 should be th and Men ?7 is marke traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numbe	r, City or Town, S	State, Zip C	Code)
	1 and 2 s of Health item 27 other tra		Gary J. Mankuli	sh / Son		429	McArthu	r Dr., R	ockville	, MD 2	0850	
Baltimore,	ge 1 au t of H lfite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐ Removal from	State	cemetery, cren	sition (Name of natory or other plac		Date	20c. Location	- City or To	wn, State
<u>=</u>	it. Pag rtmen rtant: njury		4 X Donation 5 Other (Sp				Sers. Un		17/2010	Bethe	sda,	MD
Ba	permit. Page 1: Department of I Important: If it any injury or of	A	21. Signature of Euneral Strivice big	men	M003	92 R	Name and Addre app Fune 33 Gist	ral and	Crematio 1ver Spr	n Servi	ces 20	910
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~	Physician/	1 3	Immediate Cause (Final disease or condition	_a_()	10 Acr	· M	100)	Direce				Onset and Death
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	c	Jer.	Esquentially flat conditions, if any, leading to immediate	Due to	or as a consec	quence of):	16-16-	1715	eace		-	30 7.15)
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/89	death certificate ne attending phys ed for use as the	w i	IF FEMALE:	23c. If yes, out	come of prean	ancy						
ROX	ath ce attend for us	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	Birth 2 Fel	tal death 3 🗌	Ectopic pregnand Other (specify)	су			ate of delive onth	ery Day Year
о В	the de by the ached	hysi	g Unknown	9 🗌 Unkr								
7.	that gned b	by P	Part II. Other significant condition	contributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?
Ġ,	equires	ted							1 🗆	Yes 2 No	3 🗌 Prob	pably 4 Unknown
Vital Records,	law re has be e 2 sh	Completed							24a. Was autor	osy	prior to cor	osy findings available mpletion of cause of
Ÿ	r: The		05.11/						1 \[\text{Yes}		death? 1 Yes	2 🗆 No
<u> </u>	siciar certif irecto	m l	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital:		1 mm /	_ loth	ace of Death (Cheer:				
5	g Phy er this eral d	e: 10	27. Manner of Death	28a. Date	of injury	ER/Outpatien 28b. Time of	28c. Injur	y at	Home 5 Resid	dence 6 L Oth now injury occurr)
o	eath.	licat	1 Natural 5 Pending 2 Accident Investiga	tion	th, Day, Year)	injury	M 1 □	:? Yes 2 □ No				
DIVISION OF	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin	28e. Place	of Injury - At h ng, etc. <i>(</i> S <i>pecit</i>		et, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	er or Rural	Route Number,
ם	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical					ccured at the time					d. use(s) and manner stated.
	the H thin 24 the F	Σ	only one) 3 Certifying N				eath occurred at the	e time, date and p	lace, and due to the	e cause(s) and m	anner as sta	ated.
_	5 ≥ 6 ⊗		29b. Signature and title of certifier	00	5	>	29c. License	number		29d. Date signe	i	
			30. Name and address of person when	o completed caus	e of death (Iter	m 23al (Type P	rint)	4131		N zon	4-1	7,2010
			Dernah 13	65)(44	7 3	455	Wilker	May	Ba1+	1.No- 1	ND	21223
	Stat Registra	e ir	31. Date filed (Month, Day Year) NOV 1 9 2010	Serena 32. R	egistrar's Sign	ave de la constant de						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 16, 2010 **Physician** 2:15 a. M Virginia Κ. Miller Miller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Byron House Assisted Living Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 9 Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Months 1 □ M 2 🖫 F 1907 Ohio 276-09-8208 103 Mar. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the fredien Evaninar must be notified at 10a, State 1 ☐ Yes 2 ☑ No Director MD Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. 9210 Kentsdale Dr. 20854 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 2 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Music Teacher Public Education permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grose Frank Kerns Garnet ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John B. Nicholson / Son-in-Law 1429 44th St. NW, Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Chesapeake Crematory 11/17/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral and Cremation Services MO0382 let tollmin 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** months disease or condition resulting in death) Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-tran Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

e Hospital or Attending Phystcian: The law requires that the death certificate be executed 24 hours after death. Perneral Director: After this certificate has been signed by the attending physician and Box 68760. P.O. Records, Division of Vital To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th

Saltimore, Maryland 21215-0036

Registrar

DEWNIS State

4 Homicide

29a. Certifiei

29b. Signature

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CULLEN M.D 25 WISCONSIN

and manner stated

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

2081

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 0 vear 23:20 M 112 VOL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saltimore University of Maryland Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Country) Part Chester 1 🗆 M 2 🗶 F Months Hours 087-22-9993 82 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director CTFairfield Greenwich 1 🗆 Yes 2 🗐 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12 Nedley Lane 06831 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ ō 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Corporation Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental | item 27 is marked o မ Anthony Penabare Julia Fusco permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Murgiano/ Fay Drive, South Euclid, OH 44121 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot November 20, 2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary Cemetery Greenwich, 21. Signature of Funeral Service Licensee

23a. Part 1. Enert the disease, or complications that caused shock, or the at failure. List only one cause on each line. 22 Name and Address of Facility Evans Funeral Chapel & Cremation 8800 Harford Road, Parkville, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annroximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mbolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) heart valve within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit mechanical Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months Year Day Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 \sum Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending М 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

only one) 29b. Signature and title of certifier

Greene

29c. License number

Baltimore

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:20 AM November 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Magled timore arku 8. Date of Birth
(Month, Day, Year)
(Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 9 Director 087-07-095 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ည 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road 9905 Maaled+ 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/2010 Forest Hill. Maryland apel + Cremation Services - Parkville 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death rn em i a Ph_sician/ disease or condition Medical resulting in death) Examiner testina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine teno venous attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ieral Director. After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for a Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 N Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending hours after death. 1 Tes 2 🗌 No Accident Investigation within 24 hours after deal To the Funeral Director Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # 18 Per EH G910/12/15/10 JH
State of Maryland / Department of Health and Mental Hygiene 2 0 1

1 - State Amend Item 25 per me,g909,11/19/2010dhb
Registrar amend #2 Per Phy G910 12/20/Fighth are of Death
Reg. No. 2 Date of Death 3. Time of Death Physician/ Month М ETHELEEN JONES MASON November 2010 1610 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY-Silver Spring CROSS MONTGOMERY HOLY HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Hours Min Months Director 577-64-9434 /17/1948 Favetteville.NC Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XX es 2 No Maryland |Prince George's Upper Marlboro ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 6602 Pepin Drive 20772 United States items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give "natural", Specify. Completed 3 Widowed 4 Tr Divorced Year or Dates Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Teacher DC Education Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Morrar Name (First, Middle, Maiden Surname) 2 John Taylor Jones Eala Mae Melvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Carolyn Holly / Sister 6602 Pepin Drive Upper Marlboro, Maryland 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 11/13/2010 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ INTRACEREBRAL BLEED disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CERTIFICATION BEPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical # Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has I performed? Yes 2 2 🔀 No 1 Ves funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?

1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Donpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred or Attending 1 🔀 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Auree Presidentees. To this best of my knowledge death occurred at the time, defe and place, and due to the cause(s) and manner as stated. (Check Cortifying No 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar DHMH 17 Rev 7/2009

I Fax to ME

Dami Mourad Mn

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sami Mourad, M.D.

NOV 1

9

31. Date filed (Month, Day, Year)

FM2021361

1500 Forest Glen Road Silver Spring, Maryland 20910

11/3/2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 1

9 2010

2. Registrar's Signature

		·		State of Maryla	nd/Dep ,28a-f Ce	artment of F per me.go rtificate of l	lealth and 1 209, 11/19 Death			0 36404
	Physicia /Medic		1. Decedent's Name (First, Middle, La. ALBERTA		MILL			2. Date of Dea Month	2 25 20	10 6:45 PM
	Examin Funeral Director	ier	Social Security Number 6. S	Hospital	s. last birthday) Yrs.	Baltic If Under 1 Year Months Days	More If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04/16/	y, Year) 9.	Peath A Birthplace (State or Foreign Country) ennsylvania
	show	3	10a. State 10b. County	10c. C	City, Town or Le	ocation				10d. Inside City Limits
	the Ma 28a-f	recto	Maryland N/A		Baltimo	ore 10f. Zip Code		T	10g. Citizen of What	1x Yes 2 No
	th with 23a or	ral Di	4008 - 6th Stre	et			.225		U.S.A.	
336	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be institled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates;	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □Yes 21 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Canaita	American Indian, vhite, etc. White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Ec (Specify only highest gra	l lucation lde completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired temaker	during most of work	king	16b. Kind of Busine	
	illed v I Hygie other i	Be Co	9th 17. Father's Name (First, Middle, Last)		TIOII	lelilakei	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ylan	should be tnd Mental marked oumatic ev	70 B	(not avai	lable) Fe	ese		E1i	zabeth	(not a	available)
, Maryland	and 2 sho salth and n 27 is m er traum		19a. Informant's Name/Relationship (Miriam Davis / D	**	1	ng Address (Street a			r, City or Town, Sta imore, Ma:	te, Zip Code) ryland 21225
Baltimore,	Pages 1 ament of He tant: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemova nom state	en Have		rk 10/2		20c. Location - City Glen Burn	orTown,State
Ball	permit. Departr Importa any injt		21. Signature of Funeral Service Licer	ameround	4	2. Name and Addres	nie Highw	av Balt	eral Servi zimore, Ma	ice, P.A. eryland 21225
	Physician /Medical Examiner	Examiner	23d. Part 1. Enter the disease of comshock, or heart failure List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Acute Due to (or as a conse	Rena equence of): bcapita	l Failu	re ed Fractu	re		Approximate Interval Between Onset and Death
Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consect of the conse	nancy	□ Ectopic pregnanc		VAPPROVED BY M	HOUL, MU EDICAL EXAMINER	
P.O. B	at the dear by the att tached for	Physician/M	in the past 12 months? 1 ∐Yes 2 XNo 9 ∐ Unknown	4 Pregnant at time o		Other (specify)	,		Month	Day Year
Records,	w requires that been signed I should be det	þ	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did to		te to the cause of death? Probably 4 Unknown
al Rec	h yslcian: The law r his certificate has bu I director, page 2 sh	Completed				- 41 - 1			sy prior med? deat 2 ■No 1 □	e autopsy findings available r to completion of cause of th? Yes 2 No
of Vital	nyslcia nis certi directo	To Be	25. Was case referred to medical examiner? 1 XYes -2 XHo	Hospital: 1 ☑ Inpatient 2 [☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Dea er: 4 ☐ Nursing H		<i>ne)</i> lence 6	Specify)
Division o	ing Affe	Certification: T	27. Manner of Death Thatural 5 Pending investigation 3 Suicide 6 Could not be		28b. Time of Injury 12:15	P M N N	y at	28d. Describe h	ow injury occurred	Subject tripped
Divi	Hospital or Attendi 24 hours after death. Funeral Director: A stely filled in by the fi		4 Homicide determined	building, etc. (Special Home	cify)			Baltimo	ore, MD	or Rural Route Number, 6th Street
1	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, dea nation and/or i	in occurred at the tir nvestigation, in my o	me, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and manne date and place, and	er as stated. due to the cause(s)
ソ	To the within 2 To the comple		29b. Signature and title of certifier	0		29c. Licenso			29d. Date signed (N	
			30. Name and address of person who	Kesiden+ () completed cause of death (Ite	EGY-I em 23a) (Type,) Res	5-001 South H	lanover	October	- 26 2010
	Sta		31. Date filed (Manufacture Payer Year)	0 33 Registrar's Sign			timore,	MD 2	1225	
	Registr		MAN T 2 50	y Lievas	13. 100	Star Star				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36405 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Moore 2010 3:12 AM atherine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medica TIMORE Maryland N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Min. 0 773 14 1953 214-56-3772 57 Yrs Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b County filed within 72 hours after death with the Maryland Examiner must be notified at Funeral Director 10c. City. Town or Location 10d. Inside City Limits 1 Xes 2 No MD N/A Baltimore 0 10e. Street and Number 10g. Citizen of What Country? 23a 1514 Payson St 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Social Security (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Health and Mental Hygiene. Aem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administration Claims Clerk years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ James Day Cora Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Lisa Moore(daughter) <u>5356 Lantern Ct.,Baltimore,MD 21229</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 11/20/10 Baltimore, MD 21. Signature of Funeral Service Licenses ²² Nonsend Address of Facility 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ute Physician/ SLOVOLA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ up disease Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗀 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28h Time of 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NPI#10\3233378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S GREENE ST BALT, MD SHANDER BENJAMIN M

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOA

9 2010

6.90 M

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 19.44 M Deborah Ann Matthews Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Marvland 0974971953 Yrs. Director 57 215-66-0764 Usual Residence of Decedent oms 23a or 28a-f show r must be notified at 28a-f shov 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 W. 11th Ave 21225 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or ģ 1 X Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced Year or Dates Black 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) er than " Elementary/Seconday (0-12) College (1-4 or 5+) Abacus Corp. other t 11th Grade Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hazel Matthews William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 W. 11th Ave., Baltimore, MD 21225 Marsha Adams (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/10 Baltimore, MD Druid Ridge Cem. 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Ph sician/ INFARCTION disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Litter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS PERIPHERAL VASCULAR 1 Yes 2 No 3 Probably 4 Unknown ESRD CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 20 No 1 Yes မ 10 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 14 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 14 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practiciner: To the best of my knowledge, death occurred at the time. Date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL RESIDENT Josh RES OOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO LOCH RAVEN BLVD 5601 BALTIMOKE JOSHI 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

NON 192010

DEBORAH

THEMS

32. Registrar's Signature

			For State	State of Mary				nd Menta	al Hygie	ne	0	001	0 =7
			Registrar		Cer	tificate of L	Death		Reg.	No. U	U	364	UI
	Physicia	n/	Decedent's Name (First, Middle, Last)						ate of Death onth	Dav Y	ear	3. Time of I	Death
	Medic		Helen Ruth	Norlie				Nov	vember	Day 18 20	10	03:21	AM
	Examin	er	4a. Facility Name (if not institution, give s			4b. City, Town, or				4c. County of			
and the			5812 Ritchie Stre				len Bu					rundel	
	Funeral		5. Social Security Number 6. Sex	7. Age (ln)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Da Min. (M	ate of Birth Ion <i>th, Day, Yea</i> pt. 28	ar) g	Birthpl Count	ace (State or y)	Foreign
	Director		197-26-0903 Usual Residence of Decedent		76 Yrs.			Se	pt.28	1934		PA	
	nd how at	٦c	10a. State 10b. County	100	c. City, Town or Loc	cation					10	d. Inside City	v Limits
	aryla ka-f s ified	ect	Maryland Anne Arı	ındel		G1	en Bur	nie				1 🗆 Yes	2 🔽 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	CII DUL.	11110	100	Citizen of Wha	at Count		
	vith t	ral	5812 Ritchie Stree	·+			21061		l log.	ORIZON OF THE	USA	.,.	
	ems r mu	ū		2. Was Decedent Ever i	n U.S. 13. V	Vas Decedent of Hi		? (Specify Ye	s or No-	14. Race -		n Indian	
ထ	er de or it	by F	1 ☐ Never Married 2 🙀 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	1	Was Decedent of Hi f Yes, specify Cuba	ın, Mexican, P	Puerto Rican,	etc.)		White, e		
00	rs aft ral", Exa	ed l	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1	I ☐ Yes 2 🔀 No	Specify:			Specify:	Wh	ite	
2	houl natu dical	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occup	ation		168	o. Kind of Busir	ness Ind	ustry	
2	in 72 e. nan "	E	Elementary/Seconday (0-12)	College (1-4 or 5+)		kind of work done o O NOT use retired)	during most of	t working					
2	with gien her th		12	4		Homema]	ker			Нои	seh	old .	
nd	filed d oth	o Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First,	, Middle, Maio	len Surname)			
Maryland 21215-0036	Id be Ment arke	잍	George Werner	Morgenst	ern		Kath:	ryn	Wil	ey			
ā	shou and is m		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a	and Number o	or Rural Route	e Number, City	or Town, State	e, Zip C	ode)	
·,	nd 2 ealth m 27 ner tr	Ш	Donald G. Norlie	(spouse	e) 5812	Ritchie	Stree	t, Gle	n Burn	ie, MD	210	61	
ore	e 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		 Place of Dispo cemetery, cren 	sition (Name of natory or other plac	e) N	ov. Date 2	200	. Location - Ci	ty or Tov	vn, State	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Department of Health and Mertall Hyglene. Inpartment of Health and Mertall Hyglene. any injurants if the Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	ionioval nom etate		Cemetery	7	2010	ם ו	oslyn,	PA		
<u>sa</u>	epart poord ny inj	H	21. Signature of Funeral Service Licens	i /A	22	. Name and Addres	ss of Facility	Stall	lings F	uneral	Нол	e.P.A.	
ш		0.0	Juschell L	talling	A			in Roa	d, Pas	adena,	MD	21122	
			23a. Part 1 Enter the disease, or combli shock, or heart failure. List only one	cations that caused the cause on each line.	death Do not ente	er the mode of dying	g, such as car	rdiac or respir	ratory arrest,			Approximate Interval Betw	
-4	nysician/	8 5	Immediate Cause (Final disease or condition	Met	-let	Colon	Cas	nere	-			Onset and D	eath
	Medical		resulting in death)	Due lo (or as a con	sequence of):						_	I Const.	11177
	Examiner	L	Sequentially list conditions,										
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	cuted	хап	Cause (Disease or linjury that initiated events								\perp		
	e exe	a E	resulting in death) Last	Due to (or as a con	sequence of):								
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		l							+		
6 87	rtifica ing p e as 1	/Me	IF FEMALE:										
×	th ce ttend or us	ian,	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pro 1 Live Birth 2	Fetal death 3	Ectopic pregnanc	у			23d. Date of		-	
Box	e dea the a	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5 L	Other (specify)				Month		Day Ye	ear
О	that the ned by the detache		Part II. Other significant conditions con	tributing to death but no	at resulting in the u	nderlying cause giv	ven in Part I	25	3a Did tobaco	o use contribu	te to the	a cause of de	ath?
	es th signe I be c	d by		0	3	, , , , , , , , , , , , , , , , , , ,			1 \(\sigma\) Yes	,		ably 4 🗆 U	
Ę	law requires has been sign 2 should be	etec											
ပ္ပ	law r has b e 2 sl	Completed							4a. Was an autopsy	prio	r to con	sy findings av npletion of ca	/ailable .use of
Vital Records,	vysician: The law iis certificate has director, page 2 8							1	performed Yes 2	? dea	Yes :	No No	
<u>ta</u>	cian	Be	25. Was case referred to medical examiner?	ospital:			ace of Death ((Check only o	ne)				
≥	Physical this all dir	. To	1 ☐ Yes 2 承No	1 Inpatient	2 ER/Outpatier		4 L Nursi		_	6 Other	Specify)		
0	ling l T. After funer	Certificate:	1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injury work	?		escribe how ir	njury occurred			
<u>S</u>	ttend deatl xtor: / the	tific	2 Accident Investigation 3 Suicide 6 Could not be	One Disease fairms	At hamp form atu		Yes 2 Ne	_					
Division of	or A after Direc in by	Ce	4 ☐ Homicide determined	28e. Place of Injury - / building, etc. (Sp		et, ractory, office			cation (Street ity or Town, St	and Number o ate)	r Rurai I	Route Numbe	if,
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier 1 Certifying Physic	cian: To the best of my k	nowledge death of	occured at the time	date and pla	ice and due t	to the cause/s	and manner a	e etatea	ı	7
\	e Hos 24 h e Fur leted	Medical	(Check 2 \(\subseteq Medical Examination)	er: On the basis of examine Practioner: To the best	nation and/or invest	tigation, in my opinio	on, death occu	rred at the tim	ne, date and pl	ace, and due to	the caus	se(s) and man	ner stated.
)	Nithir Forth	2	29b. Signature and title of certifier	Traditioner: 10 the Best	or my knowledge, c	29c. License		ia piace, and t		Date signed (A			
			MM	7//	3		3/15	-1	^	101/21	-	18 10	11)
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type P	Print)	10	7	1/1	\ - \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	. 1	-160	1 0
			(Inssel RO	De Limo	705	Honibe	Dir	·e . 6	ster b'	Man 13	My	2(0)	0
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	6	1)					-
	Registra	ar	NOV 1 9 2010	Terme A.	back								

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0'Neill November Biondo 16, 2010 Janice Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Windsor Mill 3419 Gaither Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Feb 11, Year 954 1 M 2 XF 56 219-56-6321 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State Director notified Windsor Mill 28a-f MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Iral", or items 23a or Examiner must be Funeral U.S.A. 21244 3419 Gaither Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐X No 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Yes. Give Specify: White "natural", Completed 3 Widowed 4 X Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) d Mental Hygiene. marked other than " PHH/ life. DO NOT use retired)
Supervisor Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental Hitem 27 is marked of other traumatic even 2 Biondo Anita Svlvester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6129 Allwood Ct., Baltimore, MD Anita M. Miller-mother permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 1 X Burial 2 Cremation 3 Removal from State Woodlawn, MD 11/19/10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee William G. Dau Ruck Towson Funeral Home, Inc. Towson, Md 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metustation on sprillell Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner scannically lin noralitum if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Certificate: To Be Completed by Physician/Medical Examine Due to (or as a consequence of) physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 attending pi IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 24a. Was an autopsy perform 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 2 Accident 5 Pending M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier only one) 29b. Signature

Approximate Interval Between 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 4 Nursing Home 5 A Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Morth, Day, Year) Sal (Type, Print) 12, Suite 302 completed cause of death (Item State ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

MaryTand

Black, White, etc.

Arval

Blackburne

1050 York Road

7:30 a M

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Olejarz Edward J. November 2010 7:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Healthcare Belair Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth July 7, 1917 1 X M 2 □ F Months Days Hours Min. New York Director 93 Yrs. 107-03-2487 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Ty Yes 2 No Maryland | Harford Belair 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 1909 Emmorton Road 21015 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Chemical Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ John Olejarz Victoria Ochal permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Mish (Daughter) 1507 Cedarwood Dr., Belair, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 11-20-10 4 Donation 5 Other (Specify) Holy Trinity Cemetery Lewiston, NY Sign ture of Funeral Service Licens 22. Name and Address of Facility Labuda Funeral Home 356 Portage Rd., Ni Niagara Falls, NY 14303 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA BILATERAL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 2 🗆 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 № No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10lls an D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH MD DHANJANI 622 S. UNION AVE, HAVRE DE GRACE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 7,8 per hosp g912 2/9tald of Maryland / Department of Health and Mental Hygiene 1-State amend 7,8,17, 24a per dr. g909tiffcate of Death

Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 05:10 AM AUGUST 190 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON MEDICAL CENTER SAINT JOSEPH BALTIMORE 8. Date of Birth 8/14/10 9. Birthplace (State or Foreign 5. Social Security Number If Under 24 Hrs. 6. Sex If Under 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Director NUNE Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200 any injury or other traumating and injury or other 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MACHUAND RAltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O. Bex 253 Columbia, MARGLAND 21045 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT エルドAルブ Be 17. Father's Name (First, Middle, Last) **0bi 0zo 0bike** 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Ben 253 YVONUE NOWYE RAMBO Colombia, MARYlAnd MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) RESERMEN CEME tox Meter 13 2010 Baltimore City Md neral Service Le 7601 BSIER DRIVE SI JESOPH MEDICAL CENTOR TOWSON, Md. 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIO RESPIRATORY disease or condition Medical resulting in death) Examiner SEVERE PULMONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events LUNG DISBASE attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical PREMATURIT P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has har ral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 🍱 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie cot D0027352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOHN LEO O'NEILL 515 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Health and Rehabilitation Center Belair cial Security Number Sex M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1921 Months Days Hours July 11 Ontario Canada 218-32-7050 Director 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If Iften 27: is marked out than "natural", or items 23a or 28a-f show any injury or rother traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2513 Fairway Drive 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Vincent O'Neill Rosella (nmn) Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1606\,$ Rolling Road, Bel Air, MD $21014\,$ Dan O'Neill / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gdn 11-19-10 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Byrial 2 ☐ Cremation 3 ☐ emoval from State Bel Air, Maryland Other (Spec 4 Onation 21. Sig ure of Fu McComas funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or comp ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical as # consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ate has been signed by the attendin page 2 should be detached for use yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate Yes or Attending Physician: the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 410 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Harsing Home 5 Residence 6 Other (Specify) hin 24 hours after death. the Funeral Director: After this 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation Accident Suicide Could not be To the Hospital or Atter within 24 hours after ded To the Funeral Director completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) title of certifie 29b. Signature 29d. Date signer (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Ishak, MD 520 Upper Chesapeake Drive, Suite 308, Bel Air, MD 21014

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For Amend Item 29 a Per dray grow, Der Registrar Co	ያ ብያ/ንድስነ of He alth and N ertificate of Death	Mental Hygiene	010 36412
	Division		1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Δ.	Physicia Medio		Gertrude Ann O'Keefe		November 12,2	.01 [°] 6 [°] 5:24А м
	Examin	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. Coun	ty of Death
			8338 Analee Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Rosedale If Under 1 Year If Under 24 Hrs.	0.0. (5:11	Balto.
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 X F 68 Yrs.	Months Days Hours Min.	8. Date of Birth Februaryear9,19	9. Birthplace (State or Foreign 42 Cowwashington, DC
	-		Usual Residence of Decedent			
	/land f sho ed at	흱	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	Mar 28a- notifie	Ĭ.	Md. Balto.	Rosedale		1 ☐ Yes 2 No
	th the	틸	10e. Street and Number	10f. Zip Code 21237	10g. Citizen o	f What Country?
	ath wi	Funeral Director	8338 Analee Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13			A continue la dien
(0	er de		1 Never Married 2 Married 1 yes 2 No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	ace - American Indian, ack, White, etc.
8	rs aft iral", Exau	Completed by	1 ☐ Never Married 2 ⅓ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:	Specia	fy: White
2-0	2 hou "natu dical	용	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki	ng 16b. Kind of	Business Industry
121	than than	E O	Elementary/Seconday (0-12) College (1-4 or 5+) Regi	DO NOT use retired) stered Nurse		hcare
2	ed wit Hygie other	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surnar	mol
an	be file ental ked c	2	John Bahlman		e F. Matthews	ne)
ary	hould and M s mai		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rura	il Route Number, City or Town,	State, Zip Code)
Σ	id 2 sl salth a n 27 i		Kimberley Mentzer DTR. 132	01 Beaver Dam Road	Cockeysville	e, Md. 21030
ore	of He of He of He of He of Hen		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposered Computer, Cremetery, Crem	ematory or other place)		1 - City or Town, State
<u>H</u>	Pagiment		4 □ Donation 5 □ Other (Specify) Bavview	11-1		.Md. 21224
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	10	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sch 9705 Belair Road N	imunek Funeral ottingham, Md.	Home ,21236
	Ph_sician/ Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or implury that initiated events C.	Carcinomo		Interval Between
Box 68760 %	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Ex		☐ Ectopic pregnancy ☐ Other (specify)		Date of delivery
P.O.	es that the dea signed by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		ntribute to the cause of death?
rds	v requires been sig should b	ted			1 Yes 2 No	3 Probably 4 Unknown
Division of Vital Records,	hysician: The law rains certificate has buildirector, page 2 sh	Completed			24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
a	Physician: The this certificate al director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		12.100 22.110
₹	hysic his ce	인	1 Yes 2 No 1 Inpatient 2 ER/Outpatient		me 5 Residence 6 🗆 Ot	her (Specify)
o ر	ling P n. After t unera	ate:	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	work?	28d. Describe how injury occur	rred
Sior	ttend death tor: / / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	006 1	to a second Double March and
ĬŽ	after after Direc	Cer	4 Homicide determined building, etc. (Specify)	reet, factory, office	28f. Location (Street and Numi City or Town, State)	per or Hurai Houte Number,
	to the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral in the funeral physics.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death			
;	the Hy nin 24 the Fu	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or invention only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge			
	Not To To COM		29b. Signature and title of certifier Thomas J. Lynch, MD	29c. License number D42196	29d. Date sign	ed (Month, Day, Year) 18/2010 2011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Thomas Lynch 301 St. Pa	i R. Vt.	MD 212	.02
	Stat Registra		31. Date filed (Month, Day, Year) 22. Registrar's Signature	Kad		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Amend Item 25 per me,g909,117,197,2010dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Mary N. Paul 5:20a M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Country) Alabama 1 M 2 X F Months Days Hours Min. (Month, Day, 08/10/ Director 417-60-7658 66 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 12 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 299 Hurley Avenue 20850 u.s.A. nit. Page 1 and 2 should be filed within 72 hours after death warfment of Health and Mental Hygiene.
ordent: If item 27 is marked other than "natural", or items; injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 Y No Black, White, etc. 1 Never Married 2 Married δ 3altimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🗶 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates. Ä<u>Krican-American</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tt Hotel 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Pitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Predella Drive, Silver Spring, Maryland 20902 Mercedes Johnson - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 11/01/2010 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Crem Ctr Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of O CERTIFICATION APPROVED BY MEDICAL EX death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown the g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page perform death? 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 00 62435 29b. Signature and title of pertifier

State Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Plint). Las B. Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 14,2010 Charles Ignatius Phelan, Sr 7:00 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3305 Appleton Avenue Carney Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Dec. 27, 1933 Social Security Number Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 XM 2 □ F 215-30-7401 Maryland **Director** 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location Director MD Baltimore Carney 1 ☐ Yes 2 ☐X\lo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 3305 Appleton Avenue USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates white 1 ☐ Yes 2 🗽 No Specify: 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Residential Surveyor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Peach Patrick C. Phelan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Phelan-spouse 3305 Appleton Avenue-Carney, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Parkwood Cemetery Nov. 17, 2010 Parkville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cancer Physician/ R Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year 1 Yes 2 L 9 Unknown Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 D 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) Natural 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse. Prantioner: To the best of my knowledge, death oncored at the time, date and place, and due to the decele) and main or selected. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) unour 103 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SGNARE DRIVE BALT IMORE 9103 FRANKLIN MD 31. Date filed (Month, Day, Year NOV 1 9 2010 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Novembo. 18 2011 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coupty of Death Examiner If Under 24 Hrs. curity Number If Und 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days Mont 1**X** M 2 □ F 67 205-34-2846 29 Sept 1943 PA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State ir than "natural", or Items 23a or 28a-f show 1 TyYes 2 ☐ No DC Director Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20009 USA 2022 Columbia Road NW Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No white Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) higher education permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If Item 27 Is marked other the any InJury or other traumatic event, Ins. 2008. English Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Francis Quirk Loretta R. Pryor မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2022 Columbia Rd. NW, Washington DC 20009 Jeanne L. Morin (spouse) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation 11-20-10 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🔲 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy perform 1 ☐ Yes 2 No 2 🗆 No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2. Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olrust D. Filh Mis

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year) NOV 1 9 2010

Susana Quinn		1- For State Registrar	state of Maryla		artment of ertificate of		and Ment		20 Reg. No.	0 36416
Physici Medical Exam								2. Date of De		3. Time of Death
· ·		4a. Facility Name (if not institut		mber)		4b. City, Town,	or Location of		er 11, 2010 4c. County of	1028 hrs
		17300 Pine Drive				Accokeek			Prince Ge	eorge's
Funeral Director		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Under	24Hrs. 8. Date of B	irth (MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director		106-28-6376	1 M 2 X F		80 Yrs	. IVIOTICIS D	ays Hours	Aug 1	1, 1930	Mexico
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	on				10d. Inside City Limits
* .	5	Maryland Prin	ce George'	S	Accoke	ek				1 Yes 2 No
733/ h the Maryland 3a or 28a-f sho	Director	10e. Street and Number		<u> </u>	_	10f. Zip Code			10g. Citizen of Wha	t Country?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	iO K	17300 Pine Dri				206			USA	
sath wi	Funeral	11. Marital Status 1 Never Married 2		*				n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - White,	American Indian, Black, etc.
ifter de Il", or		3 Widowed 4 D	1 Yes vorced If Yes, Give Year	24 No	1 X	Yes 2 N	No specify:	Mexican	Specify:	Hispanic
hours a	ed by	15. Decedent's Education (Sp			16a. Deceden	t's Usual Occup ost of working li	pation (Give kir	nd of work done	16b. Kind of Busi	
7 , _	ompleted	Elementary/Secondary (0-12) College (1	-4 or 5+)		spector		se retired)	2M Co	mp and
5-00 led with Hygiene other t	Com	17. Father's Name (First, Middle	, Last)		Tr	ispector		Name (First, Middle,		mpany
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Franciso Guerr						Ramona Di	az	
O 4 5 2 2	မှ	19a. Informant's Name/Relation						er or Rural Route Nu		
두 당점 모루		Ramona Lanatho 20a. Method of Disposition		20b.	Place of Disposi			Mira Lo		/52 ity or Town, State
		1 Burial 2 Cremation		m State	crematory or oth tro Crem	er place)		1/18/10		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee Thoma	s Grego						re, Maryland
		Vomow	Duy		299	Freder	cick Ro	ad Baltim	ore, Mary	iand 21228
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.		i. Do not enter th	e mode of dying	g, such as card	diac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Ather Due to (or as a		otic car	diovaso	cular d	isease		Death
	_	Sequentially list conditions,	b	<u> </u>						
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c	consequence o	ıf):					
ed nsit	Examine	events resulting in death) Last	Due to (or as a	consequence o	of):					
iO, e be executed ysician and burial - transit	edical	X UNPENDED	d. AMENDED 7	M	- 000 1	1/20/10				
760, cate be	Med	IF FEMALE:	23c. If yes, or	per Mi utcome of preg	E g909 1	1/30/10) TT		23d. Date of de	livery
Box 6876(death certificate the attending physical for use as the b	cian/Me	23b. Was decedent pregnant in t past 12 months?	I Live bir	rth int at time of de	ath	al death 3	Ectopic p	regnancy	Month	Day Year
Boy e death the att	Physi		known 9 Unknow	wn	3 <u></u> ∪th	er (Specify)				
, P.O. E ires that the d signed by the	by P	Part II. Other significant condition	ions contributing to	death but not re	esulting in the ur	nderlying cause	given in Part I			te to the cause of death?
ords, I w requires is been sig should be										Probably 4 Unknown re autopsy findings available
Records, The law require ficate has been si	Completed							autop		r to completion of cause of
tal Rec		25. Was case referred to medica	1			26 Plac	ce of Death (Ch	1 Yes	2 No 1	Yes 2 No
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		Other:		Residence 6	Other: Scene
Division of Vital lal or Attending Physician rs after death. al Director: After this certiced in by the funeral director.	n: T	27. Manner of Death 1 X Natural 5 Death		f Injury Day,Year)	28b. Time of In		ury at Work?		how injury occurred	
Sion Attend r death ector: by the	cati	Pen	stigation	of laine. At he			Yes 2 No			
Div spital or ours afte teral Dir filled in	Certification:		d not be Specify)	or injury - At the	ome, farm, street	, ractory, office	bullaing, etc.	or Town, S		or Rural Route Number, City
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis of	examination as	ge, death occurre	ed at the time, d	date and place,	, and due to the caus red at the time, date	e(s) and manner as	stated. to the cause(s)
To COI	Me	29b. Signature and title of certific	and manner sta	ited.		29c. Licens				(Month, Day, Year)
		30. Name and address of person	HELCC.	d /	2201	O.C.	.M.E.		November 12	, 2010
bond			sistant Medical F	vaminer	111 Donn St	reet, Baltim	ore, MD 2	1201		
St	_	31. Date filed (Month, Day, Year)	32. Reg	istrar' Signatu	all.					
Regist	nen	MATATOIO	Line	14. 15	The same of the sa					

10-08610 John D. Rogers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	ate of Dea	ath		, 0	Reg. No.	110	3041
Physici		Decedent's Name (First, Middle, La	st)		•			2. Date of De	eath	ar	3. Time of Death
ledical Exami	ner	John David Rog			Lu au				er 9, 2010		1530 hrs
)		4a. Facility Name (if not institution, gi 1810 Rambling Ridge La				, Town, or Lo esville	cation of Dea	ath	4c. County Baltimo		
Funeral		Social Security Number 6. 8		rs. last birth		nder 1 Year	If Under 24H	rs. 8. Date of E	Birth (MM/DD/YYY		
Director			Ωм 2 Г 63		Yrs. Mon			lin.	21, 1947	Foreig	n
		Usual Residence of Decedent	2 1 03			لـــاـــا		July	21, 1747	wes	yt ^{ry)} Virginia
Any		10a. State 10b. County	10c.	City, Town	or Location						10d. Inside City Limits
nd show	_	WV Monongal	ia	Morga	ntown						1 Yes 2 X No
Aaryland 28a-f show	Director	10e. Street and Number				ip Code			10g. Citizen of W	hat Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once		96 Northwoods Dra	lve		2	6508			U.S.A.		
n with	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.				Specify Yes or Norto Rican, etc.)			can Indian, Black,
or ite	E	1 Never Married 2 X Marrie	1 X Yes 2 1			-44		nto Rican, etc.)	VVIIII	e, etc.	
s after	ģ		or Dates: 1969-1		1 Yes		specify:		Specify:	Whi	
5-0036 led within 72 hours tygiene. other than "natur the Medical Exam	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)		ecedent's Usua Juring most of w				16b. Kind of Bu	usiness/li	ndustry
36 bin 72 than	ple	Lienteritary/Secondary (0-12)	4	Ra	diology	Techr	ician		Hosp	ita1	ı ·
5-0036 ed within 7. tygiene. other than	Completed	17. Father's Name (First, Middle, Las			410106)			me (First, Middle	, Maiden Surname		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Joseph Lee Rogers	5			M	argie	King			
21 nould is man	မ	19a. Informant's Name/Relationship (100					umber, City or Tov		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ah injury or other traumatic event, the Medical Examiner must be notified at once		Linda Sue Rogers					-		wn, WV 2		
nore, ages lar nt of Hee		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	Ob. Place of	f Disposition (N ory or other place ant Hil	ame of ceme २६)	tery,	Date	20c. Location	- City or	Town, State
Baltimore, permit. Pages 1 at Department of Het Important: If ite		4 Donation 5 Other Specif	<i>r</i> :	Cemet	ant Hll ery	1	11	l-15-201	0 Morgan	towr	ı, WV
Balt permit. Departs Import injury		21 Signature of Funeral Service Lice	4		22. Name ar	nd Address of	Facility	Home T	nc		
	V 13	James of 11	Mun		153 S	pruce	St., N	forganto	nc. wn, WV 2	6505	
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	ach line.			e or ayırıg, su	on as cardiad	or respiratory a	rrest, snock, or ne	art	Approximate Interval Between Onset and
Examiner	1 1	Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Card		ar Disease						Death
			. Due to (or as a consequen	ce or).							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen-	ce of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen-	ce of):							
uted id ansit		events resulting in death). Last									
e exectian ar	ica	UNPENDED	AMENDED								
760, ficate be ex g physician the burial -	//Medical	IF FEMALE:	23c. If yes, outcome of						23d. Date of	fdelivery	1
687 Sertification	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of		Fetal deat		Ectopic preg	ınancy	Month	D	Day Year
Box 68' e death certifi the attending ed for use as	Physiciar	1 Yes 2 No 9 Unknow		or death 5	Other (Sp	ecify)					
D. E		Part II. Other significant conditions	contributing to death but r	not resulting	in the underlying	ng cause give	en in Part I.	23e, Did	tobacco use contr	ibute to t	the cause of death?
P.O.	ğ							1 🗌 Y	es 2 No 3	Prob	pably 4 🗹 Unknown
rds requi	Completed							24a. Wa			topsy findings available
e law te has ge 2 s	Ĕ				-			per	formed?	death?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical		_		26.Place of	Death (Chec		2 V NO	Ye	s 2 No
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Ou	tpatient 3				Residence 6	Other	: Scene
ling Ph	늘	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. T	ime of Injury	28c. Injury a	at Work?	28d. Describe	how injury occur	red	
ion tendi for: /	읉	1 V Natural 5 Pending 2 Accident Investigation				1 Yes	2 No				
Division tal or Attendi sa Birector: A led in by the fu	띭	3 Suicide 6 Could no	be 28e. Place of Injury -	At home, fai	m, street, facto	ry, office buil	ding, etc.	28f. Location or Town,		er or Rur	ral Route Number, City
Spital nours a neral I	Certification:	4 Homicide determine	ed (Specify)					or roun,	- Clato)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans			ian: To the best of my known: On the basis of examination								
To the withing To the company	Medical	29b. Signature and title of certifier	and manner stated.	on unurui III		9c. License r		s at the time, dat	29d. Date sign		
	=	Lie Co	MS		2	O.C.M.			November 1		
		30. Name and address of person who	completed cause of dooth (Itom ??=\		J. J. 141.				, 20	
			Medical Examiner 1		Street, Bal	timore, MI	D 21201				
S	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	pature	,						
Regis		NOV 1 9 2010	32. Registrar's Sig	ares							

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	1	For State		Sta	ate of M	arylan		artment of <i>tificate of</i>		and N	اental Hyg. ت	giene Reg. No.	nin	36418
		Registrar 1. Decedent's Name (F	First, Middle	e, Last)				imouto or			2. Date of Dea	th	Voor	3. Time of Death
Physician. Medica		Thoma		1.		y-ers	<u> </u>	г			Month	Day 2	- 2010	
Examine		4a. Facility Name (if no				ما ۵۵	ndr	46. City, Town			uruland		County of Deat N/A	th
Funeral		5. Social Security Num		Sex 1 M 2	7. Ag	e (In yrs. k	ast birthday)	If Under 1 Yes	r If Unde	r 24 Hrs. Min.	8. Date of Birth	h	9. Bir	thplace (State or Foreign
Director	-	184-46-246		1 M2 M 2		51	Yrs.				Dec. 28	1958	Ferr	sylvania
show d at	- 1		0b. County			10c. City	y, Town or Lo	cation						10d. Inside City Limits
e Mary r 28a-1 notifie	Director	PA 10e. Street and Numb		ork			Dall	astown_				10a Citi-	zen of What Co	1 🕅 Yes 2 □ No
vith the	<u>a</u>	42 West Ho		Stroot	_				313			rog. Oniz	USA	, and y
leath vitems	- 1	11. Marital Status	JWALU_	12. Wa	s Decedent ned Forces?		S. 13. \		Hispanic O	rigin? (Sp	ecify Yes or No- Rican, etc.)	1	14. Race - Ame Black, Whit	
after or samir	d by	1 Never Married 3 Widowed 4		ried 1 [Yes 2 12 es, Give ar or Dates.		- 1	I□Yes 2☑	,			s	Specify: Whi	
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2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at		19a. Informant's Nam				htor		•			al Route Number ork , PA.			p Code)
1 and if Heal item 2 other	ŀ	Cortney R 20a. Method of Dispos	sition			20b. F	Place of Dispo	sition (Name of natory or other p			Date		cation - City or	Town, State
Page ment o ant: If ury or		1 Donation 5			al from State	' 1	mation D	irect Ser	viœ	11/16		York,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral Service	1			22	2. Name and Ad	lress of Faci	Char	men-Harri Baltimore	is Fur	eral Ho	ne 215
		23a. Part 1. Enter the	disease, o	r complication	s that cause	d the deat							-1.4424 = 7	Approximate Interval Between
Ph_sician/		shock or heart Immediate Cause (Fir disease or condition		only one caus	ardio	MVO	pothy							Onset and Death
Medical Examiner		resulting in death)		ſ.	Due to (or as	a consequ	uence of):	1						
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6 E 6	- I	resulting in death) La	st	L _d	Due to (or as	a consequ	derice oi).							
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ian: Th rtificate rtor, pa	Be C	25. Was case referred examiner?	to medical					26	Place of De	eath (Chec	1 Yes	2 A No	ol 1 re	s Z ALINO
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.		29a. Certifier 1	Certifyin	n Physician:	To the hest o	f my know	ledge death	occured at the t	me. date an	d place, a	nd due to the ca	use(s) an	d manner as si	tated.
To the Hospital within 24 hours of the Funeral I completed filled	Medical	(Check 2	Medical	Examiner: Or	the basis of	examinatio	n and/or inves	tigation, in my or	inion, death	occurred a	at the time, date a ice, and due to th	and place,	and due to the	cause(s) and manner stated.
To the Complex		29b. Signature and tit	le of certifie						nse number				e signed (Mon	
		30. Name and addres	s of person	who complet	ed cause of	death (Iten	n 23a) (Tyne I	Print)	708			1.1	112/2	e (0
		MURTAZA	DA	MOOD		22 5	S. GRE	ave st	NYK	194	BALTIN	NOFE	= M	\$ 21201
State Registra		31. Date filed (Month,	Day, Year)	1 9 20	32. Regis	ar's Signa	ture	parts	,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 24,25,29 per dr. g909 L1/19/10 kh 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:25 \mathbf{a}^{M} October 2010 Maliah Annette Rocke Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Towson Center if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** oct 1, 2010 1 □ M 2 🗓 F Months Hours 2Min. Maryland Director infant Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Windsor Mill MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21244 7412 Lexham Court permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. <u>ک</u> 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tajina Wilson ည Anthony Rocke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21204 19a. Informant's Name/Relationship (Type, Print) 6701 N. Charles Street Baltimore, MD Greater Baltimore Medical Ctr 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Rona 21201 timore MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner compe Sequentially list conditions Due to (or as a consequence of): rr any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician: The law requires that the death certificate be executed the attending physician and ned for use as the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Other (specify) Pregnant at time of death 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be completed filled in by the funeral director, Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Name | 1 Impatient 2 | ER/Outpatient 3 | DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Certificate: work? iniury To the Hospital or Attending 1 Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: John best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Annette

Mal

0

6565 N. Charles St Ste 613

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

larrold Elberfeld, MD

31. Date filed (Month, Day, Year)

Bathmore, M

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 6:15 Naomi Eleanor Reinhardt Vovember Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Twy Hall Geriatric Center <u>Baltimore</u> Baltimore If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Months Days Min. May 20 Hours Director 220 - 05 - 3898 90 Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 1320 Windlass Drive LISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: White Completed 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail Store N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental I ည Frederick G. Hamel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Mary Schirmer injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Beverly Moxley (daughter) 3174 Chester Oak Road Guthrie. OK 73044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 17. Gardens of Faith Cenetery Baltimore County, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility £. 3. Lassakn Lassahn Funeral Home 7401 Belair Road Baltimore, MD. Approximate Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Ons t and eath Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) nsequence of): don Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a insequence of Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 L Fela 30in the past 12 months? certificate has been signed by the rector, page 2 should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by QVe = Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 1 Yes 2 No __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 24 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 ho

To the Fune

completed f (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)
11 - 16 - 2010 29b. Signature and title of certified M-D ASTERN BLVD, MD-21221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 ASCRIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 19 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:45 AM 17 2010 Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold 636 Dunberry Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ F 88 Yrs. 185-14-8346 Pennsylvania Director July 28, 1922 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐No Arnold Director . MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21012 636 Dunberry Drive Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2X No Yes, Give within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No White Specify: 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 1 and 2 should be Health and Mental is marked Ethel McCrea Perry Allen ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Graceville Ave., Mountain Top, PA 18707 N. Thomas Robertson / Son or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' Important: If its any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department o Baltimore, Maryland Metro Crematory Inc. 11/18/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore
23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd., Baltimore, Maryland 21228 immediate Cause (Final disease or condition resulting in death) **Physician** Cercovese /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Ö 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1□ Yes 2 No **Division or Vital** Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🗙 No 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No o the Hospital or Attendii Ithin 24 hours after death. The Funeral Director: A death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D002088 11/17/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1509 31. Date filed (Month, Day, Year)
NOV 1 9 2010 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 28e, f per me 9912 2-25-11 ye. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, 2. Date of Death Last Year Physician/ 3 P Medical 4a. Facility Name (if not institution, give street ocation of Death 4c. County of Death **Examiner** N/A If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age In yrs. last birthday 6. Sex **Funeral** oc4 1 Day 1 968 1 🗆 M 2 🍱 Hours Min. Mary Tand 42 Yrs. Director 215-80-0747 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a. State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must <u>be notified at</u> Completed by Funeral Director 1 🗆 Yes 2 🗶 No Catonsville MD Baltimore the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21228 717 Kent Avenue USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Inforciant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner myonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 🗆 Widowed 4 🗀 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Service Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Ruff Judith Becker Marvin Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Kent Avenue Catonsville, MD Ashley M. Ruff, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 11/18/10 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee George, MacNabb 22. Name and Address of Facility MacNabb Funeral Home, 301 Frederick Road Catonsville, MD Do not enter the made of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or conflications that caused the death shock, or heart failure. List only one see on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani disease or condition Medical resulting in death) Examiner Ecquertially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner attending physician and for use as the burial-transit resulting in death) Last IF FEMALE: s, outcome of pregnancy Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic preg in the past 12 months?

1 Yes 2 No
9 Onknown Month Day Pregnant at time of death 5 Other (spe 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause Certificate: To Be Completed by

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 tor: After this certificate has been signed by the true tuneral director, page 2 should be detached completed filled in by

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		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ Mo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
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3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		f 21920 S treePay som oStral Ball respis.
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

State Registrar

Medical

(Check only one)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:29 PM Richard Lee Stahl, Sr. NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) WV 6. Sex Funeral 1 X M 2 □ F Hours 04 Month Day 940 70 Director 213-36-3878 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any joines. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Street 1 ☐ Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21204 3312 Dublin Manor Rd 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Corporation Machine Mechanic 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth Pauline Knotts Oliver Wood Stahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2156 Kyle Green Rd Abingdon, MD 21009 Hope R. Huster (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Mem. Gardens 11-17-2010 Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CARDIOGENIC SHOCK disease or condition resulting in death) Medical **Examiner** ACUTE MYOCARDIAL INFARCTION Sequentially list conditions ii any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir Hospital or Attending Physician: The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the g Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy perform Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? 1 X Yes Hospital 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work neral Director: A filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier D63974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 6:50 A^{M} Winona November S. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🖳 F Davs Hours Min. (Month, Day, Director 213-10-8522 92 917 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Baltimore Towson Md.10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1422 W. 21204 Joppa Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes fif Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:White "natura!" 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important; If feen 27 is marked other than "na any injury or other traumatic event "the conce." (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Olive L. Siepp Wilbur S. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8503 PleasantPlains Rd. Towson, Md. 21286 Mr. Wilbur H. Smith/ Nephew 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 11-20-10 Timonium, Md. 4 Donation 5 Other (Specify) 21. Signature of Fu ral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Debilita Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury consequence of as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Year Pregnant at time of death 5 Other (specify) 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an las l autopsy performed? Yes 2 No death?
1 Ves 2 No within 24 hours after dearn.

To the Funeral Director: After this certificate hombleted filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS D 2 No 9 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sidi nature a 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Suite 4105, Baltinuere, MO 21104

ss of person who completed cause of

32. Registrar's

10-08640	Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	_egible.	
Gilbert Floyd Shilts, III	State of Maryland / Department of Health and Mental Hygiene	2010	351
1- For State	Certificate of Death	Des No	

		- For State Registrar			Certifica	ate of D	Death				eg. No.	t V		00121
Physician	1/	1. Decedent's Name (First, Middl					_			2. Date of Dea Month	Day	Year		3. Time of Death
Medical Examin		Gilbert Floy			II	Las	011			Novembe	r 10, 2	010 County of		2250 hrs
		4a. Facility Name (if not institution 2202 Greenery Lane /		imber)			City, Town, or Silver Sprin				М	ontgom	ery	
Funeral	T	5. Social Security Number	6. Sex	7. Age (In	yrs. last birtl	_	If Under 1 Yea Months Day			1			Foreign	
Director	L	391-02-7065	1 X M 2 F	32		Yrs.	World S Day	Tiodis	iviii).	Feb.	17,	1978	Cou	ntry) WI
yna	-	Usual Residence of Decedent 10a. State 10b. County		100	. City, Town	or Location								10d. Inside City Limits
≱		MD Montgo	0m0*11		•	er Sp	ring							1 Yes 2 No
uryland 8a-f show at once	황	10e. Street and Number	omery		DIIV		Of. Zip Code		-	1	10g. Citiz	en of Wha	at Count	ry?
he Mz	Director	2202 Greenery	Tano				20906				US.	Δ		
with with		11. Mantal Status	12. Was Dec		r in U.S.		ecedent of His					4. Race -		an Indian, Black,
death death	Funeral	1 X Never Married 2 Married	1 X Yes	2	No	if Yes,	specify Cubar	n, Mexican	, Puerto R	ican, etc.)		White,		
s after ral",	<u> </u>		orced If Yes, Give Yea or Dates:		i) 140		s 2 X No					Specify:	Whi	
hour natu	멸	 Decedent's Education (Specific Elementary/Secondary (0-12) 	College (1				Usual Occupation of working life				160. K	nd of Bus	iness/in	dustry
36 hin 73 e. than edical	Completed	zionanary/socondary (o 12)	4	, , 6. 6 ,	La	b Tec	hnicia	n			Sci	entii	Eic	Research
5-0C ed wil fygien other	탉	17. Father's Name (First, Middle,	· ·						's Name (I	First, Middle,				
21. De fil be fil rrked rrked	8	Gilbert Floyd		Jr.						unders				
D 27 should and Me is ms	٩	19a. Informant's Name/Relations			1.0	-	ddress (Stree					•		
, MI and 2: ealth a	ŀ	Ruth Shilts - 20a. Method of Disposition	Mother	Т			tle Cr			Detava				own, State
Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 72 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-1	1 Burial 2 X Cremation			cremato	ry or other	place)		11_2	0_2010	ŀ		-	
Itim it. Pa rrant y or c	1	4 Donation 5 Other So 21 Signatur of Funeral Service	CCTI):		Crema	iern]	ne and Address			ase-De				khorn, WI
Ba Depa Imp	-	V punch	Hum	-			eral Ho		110					
Physician	十	23a. Part I. Enter the disease, or failure. List only one cause		aused the	death. Do no									Approximate Interval Between Onset and
Medical Examiner	ı	Immediate Cause (Final disease		uranc	e into	xicat	ion							Death
Zxammor	-	or condition resulting in death)	Due to (or as a	conseque	nce of):									
	声	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conseque	ence of):									
	틽	Cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a	conseque	nce of):							_	- 27	
ecuted and transit	/Medical Examiner	events resulting in death) Last	d.	Conseque			_							
e exection a linial - (8	X UNPENDED	AMENDED 23a	.PII.	27 . 28 <i>a</i>	-f. p	er ME	g910	12/7	/10 TT			_	
68760, certificate be noting physici sc as the buri		IF FEMALE: 3b. Was decedent pregnant in th	23c. If yes,	outcome or	rpregnancy			Ectopic			230.	Date of o	_	Voor
Sox 687 death certific e attending for use as t	lä	past 12 months?	I I LIVE D	oirth ant at time	of death 5	Fetal	death 3 (Specify)	Ectopic	c pregnan	су	- h	Month	Da	ay Year
Box e death c the atten	Physician	1 Yes 2 No 9 Unk	known g Unkno	own			(-)//							
.O. that the	Dy P	Part II. Other significant conditi	-		_			given in Pa	art I.			_	_	ne cause of death?
S, F. luires I luires	<u>8</u>	Atherosclero	tic cardi	ovasc	ular c	iseas	se			24a. Was				opsy findings available
aw requas bee										autop		pr		empletion of cause of
Rec The I page	Completed									1 Yes			✓ Yes	2 No
of Vital Records, P.O. ng Physician: The law requires that the Riberthian or the thank there is signed by meral director, page 2 should be detacted.	a R	25. Was case referred to medical examiner?	Hespital:		o∏ ED/O			of Death Other			Desides	nce 6 🗸	015	Page 2
of V Phys ter this	<u>-</u>	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury		tpatient 3		ry at Work		8d. Describe	,		.,	Scene
on C arth. Tr. Aff	[]	1 Natural 5 Pend	(Month	, Day, Year)	10 Fd	10.50	` ₁□,	Yes 2	_	unk				
Division tal or Attendi rs after death. al Director: A led in by the fu	<u></u>		stigation Fd 11				actory, office b	ouilding, et	c. 2	8f. Location (Street	d Numbe	r or Rura	al Route Number, City
Div pital o ours af eral D	Certification:	4 Homicide deter	mined (Specify)	fou	nd at	resid	lence		А	pt ^{or T} 2002	Stars 1	ver	Spri	al Route Number, City nery Lane ing, MD
	ल	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician; To the bes	of examina	owledge, dea tion and/or in	th occurred vestigation	at the time, da , in my opinion	ate and pla n, death oc	ace, and d curred at	ue to the caus the time, date	se(s) and and plac	manner a	as state e to the	d. cause(s)
¥.2 ± 8	₽ 	29b. Signature and Hile of pertifie	and manner s	natou.			29c. Licens	se number			29d. D	ate signe	d (Mon	th, Day, Year)
	-	/ / /	1				O.C.	M.E.			Nove	ember 1	11, 20	10
OCME	r	30. Name and address of person	· · · · · · · · · · · · · · · · · · ·							. 0400:		<u> </u>		
		Mary G. Ripple MD. 31. Date filed (Month, Day, Year)	Deputy Chief N	Medical egistrar's S		111 P	enn Street	, Baltim	ore, MD	21201				
Stat Registra		NIOV 4 0 01	110	ogiotical S S	A A	a de	/							
DHMH 17 Rev 1/200)1	NOV 1 3 20	JIU JOSHA		ORI	GINAL								

DHMH 17 Rev 1/2001 OCME 2006

Division of Vital Records, P.O. Box 68760 within 24 hours after To the Funeral Dire

Baltimore, Maryland 21215-0036

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

29b. Signature and title

and manner stated.

rson who completed cluse of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

hoice Lane, Baltimore, MD 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 State of Maryland, 1Penaring hold Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 08 2010 8:30 Ruth H. Sparrow /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne Arundel 8558 Beacon Point Drive If Under 1 Social Security Number . Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 F 91 10/04/1919 Director 218-22-2411 Kentucky Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 No Director Baltimore MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 1609 Cole Street United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Craycraft Lucy McGuire ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suella Waltermyer (Daughter) 8558 Beacon Point Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/11/2010 Elkridge, Maryland Meadowridge Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 2 weeks neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed attending physician and Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughters Residence Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death. 24 hours after death Funeral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Schuler camp

31. Date filed (Month, Day, Year)

OakBirt

32. Registrar's Signature

Pasalina md 21122

		1 For Amend Ite	State of Maryl ms 25,27,28	and Department	artment of h me, g909, tificate of l	191/19/2 0 Death	Mental Hygi	ene g. No. 0 0	35430
Physici /Medic	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give si	reet and number)	Sc	Uer 4b. City, Town, o	r Location of Deat	2. Date of Death Month	Day Year	3. Time of Death
Examin	er	The Johns Hopkins Hos 5. Social Security Number 6. Sex	spital	yrs. last birthday)	Baltimore	City If Under 24 Hrs	8. Date of Birth	N/	'A hplace (State or Foreign
Funeral Director		N/A 1X	M 2 F	84 Yrs.	Months Days	Hours Min	(Month, Day,	Year) Con 02 1926	PA
72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		. City, Town or Lo		Pasadena			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
vith the a or 28: be notif	Director	10e. Street and Number	a		10f. Zip-Code	21122	10	g. Citizen of What Co	
, or items 23 miner must	y Funeral	1 ☐ Never Married 2 ★ Married	Was Decedent Ever i Armed Forces? No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ⅓No	21122 dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: WI	rican Indian, e, etc.
tall High men returned and man the may remain the may remain that Highene. event, the Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo		16b. Kind of Business	•
Hygien other th ont, the		12 17. Father's Name (First, Middle, Last)	4		Teache		ame (First, Middle, M		Schools
Mental I arked o	To Be	William Sau	er			Margar	et D.	Moore	
and is m aum		19a. Informant's Name/Relationship (Typ	<i>,</i> , ,		,			City or Town, State, 2	
of Health fitem 27 rother tr		James Sauer 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re		Ob. Place of Dispo		i	Date 2	ark, MD 207 20c. Location - City or	
tment rtant: I njury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Progral Service Licenses	1		ematory I	nc.	2010 B	Baltimore,	Maryland Home, P.A.
Impo any ir		In Sta		70	3111 Mou	ntain Ro	ad, Pasad	lena, MD 21	· ·
ysician Viedical		23a. Part 1. Enter the deease, or complishock, or heart failure. List only of disease or condition resulting in death)	ations that caused the cause on each line. APNER Due to (or as a cor	7	er the mode of dyl	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
hysician and the burial-transit	edical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor		HEMA	TOM F	JG WITHOUT APPEROVED BY MEDI	CAL EXAMINER	
ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [Ectopic pregnand Other (specify)	Σ y		23d. Date of de Month	livery Day Year
sign Id be	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying cause g	iven in Part I.	23e. Did tob	pacco use contribute t s 2 ☐ No 3 ☐ Pr	
has ge 2	Completed						24a. Was an autops perform	y prior to	utopsy findings available completion of cause of
s certificate director, pa	Be	25. Was case referred to medical examiner? 1 X Yes 2 X He	ospital: 1 Inpatient	2 ER/Outpatier	ot 3 DOA Oth	or:	ath (Check only one	nce 6 🗆 Other (Spe	cify)
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	itlon: To	27. Manner of Death 1 Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year Unknown	28b. Time o	of 28c. Inju	ry at	28d. Describe ho	w injury occurred ole falls	
s after des Il Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - / building, etc. (Sp Home	At home, farm, str ec <i>ify)</i>	eet, factory, office		28f. Location (St. Cify or Town	reet and Number or R State) Edgewa: Pasdena	ter_Road
24 hour Funera stely fills	edical		ician: To the best of my ner: On the basis of exar and manner stated.						
within 2	Med	29b, Signature and title of certifier	and marrier stated		29c. Licens			9d. Date signed (Mont	
		1017	, M.D.			5-000	\[\lambda\]	lovember	3, 2010
		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print)	600	North Wol	fe St, Baltim	ore, MD, 21287
Sta Registi		31. Date filed (Month, Pay Year)	32. Registrar's S	ignature.	and a second				

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		artment of H			giene Reg. No.		36	131
	Physici /Medic		1. Decedent's Name (First, Middle, Last	-	ible	ath Day	Day Year 3. Time of Death					
	If Health and Montal Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show and item 27 is marked other than "natural", or items 23a or 28a-f show and item 27 is marked other than "natural", or items 23a or 28a-f show and item 27 is marked other than "natural", or items 20a or 28a-f show and items 20a or 20a o		4a. Fability Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death 4c. County of Dea Baltimore City						
				7. Age (In yrs. Ia M 2 F X 5 7	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th ly, Year) 15 , 19	9. Birthp Coun 953 Was	olace (State try) shing	DC
Maryland		tor	Usual Residence of Decedent 10a. State 10b. County MD Howai	,	, Town or Lo	ocation oodbine					1 Ves	City Limits
th with the		al Director	10e. Street and Number 1900 Daisy Ro		10f. Zip-Code	21797	10g. Citiz	Citizen of What Country?				
036 urs after dea		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify:					14. Race - American Indian, Black, White, etc. Specify: white		
1215-0036 within 72 hours aft		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	Drug	6b. Kind of Business/Industry rug and Alcohol Treatment				
⊆ 8:		To Be Co	17. Father's Name (First, Middle, Last) Joseph A. Ko		Nurse / Counselor 18. Mother's Name (First, Midd) Natalie Scar				·			
, Maryla and 2 should		-	19a. Informant's Name/Relationship (7) Karl Scible /		I a	ng Address (Street						
<u>e</u> - :			Karl Scible / husband 1900 Daisy Rd. Howard Co, MD 21797 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory Balto, MD									
Dalti.	Department of Important; If any injury or once.		21. Junature of Funeral Service Licensee Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213									
Phy	hysician		23a. Part 1. Enter the disease, or complications that caused he ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Candidal Urosepsis									
	ledical aminer	_	resulting in death) Sequentially list conditions,	b. Due to (or as a consequence of the consequence o	ience of):		ph rosis					
ecuted	ate has been signed by the atten page 2 should be detached for i	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Obstructive hydrone phrosis Due to (or as a consequence of): Neurogenic bladder Due to (or as a consequence of):					V.			
X 68 / 60, certificate be executed		edical	•	d. Multiple								
death		Physician/M	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnand Other (specify)	2	23d. Date of delivery Month Day Year		Year		
J. #		by	rate in Other significant conditions continuumly to death but not resulting in the underlying cause given in Part i.						Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown			
The law		Completed		<u>.</u>		24a. Was autor perfo 1				prior to completion of cause of death?		
VITAI		Be	25. Was case referred to medical examiner?	Hospital:	-	ot a DOA Oth	or:	eath (Check only o				
or hys	무교	2	1 ☐ Yes 2 XNo 27. Manner of Death	1 ■ Inpatient 2 □ I 28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3 LI DOM	4 🗆 Nursing	Home 5 Residence Residence Residence Figure 1 Residence			y)	
OIVISION or Attending	after death. Director: After in by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Place of injury - At home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number,				mher
DIV												
To the Hospital		Medical		Iner: On the basis of examinati and manner stated.			opinion, death oc		, date and		to the cause	e(s)
2		~	C' + M								7 00	10
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)		North Wo		mber 1	1 00	0100=

State Registrar 31. Date filed (Month, Day, Year) NOV 19 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 25 per me,g909,11/19/2010dhb
Registrar

State Of Maryland / Department of Health and Mental Hygiene
Per me,g909,11/19/2010dhb
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** WILLIAM 191221 OCTOBER 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTELLOWN KENT If Under 1 Year f Under 24 Hrs. 8. Date of Birth (Month, Day, May 31, (In yr. Birthplace (State or Foreign Country) **Funeral** Months Min. 1 ☑ M 2 ☐ F May **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Example data once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐Yes 21KINo MD Kent Worton 10g. Citizen of What Country? 10e Street and Number 10f Zin Code USA 21678 24345 Smithville Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black, White, etc 1 Never Married 2 Married white 1 ☐ Yes 2 🛂 No þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation Un 16b. Kind of Business/Industry un 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname)unk Be P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester River Hospital Center 100 Brown Street; Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State 21. Signature of Euneral Service Licensia 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final o Vascu ArteroSclovetic 3 months resulting in death) /Medical Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Be Completed by Physician/Medical attending p for use as t

Physician Examiner

Baltimore, Maryland 21215-0036

After this certificate has been signed by the a funeral director, page 2 should be detached for within 24 hours after death

To the Funeral Director:
completely filled in by the

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. d.	c. Due to (or as a consequence of): ###################################									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3 Ect					23d. Date of do Month	elivery Day	Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did							23e. Did tobacc	id tobacco use contribute to the cause of death?			
M. L. L.							1 ☐ Yes	es 2₩ No 3□ Probably 4□ Unknown			
Cardioleyopet Hx Lung Surso	hy D	Vug Eluting S	24a. Was an autopsy performed								
25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
1 X Yes 2 2(No	Ho	spital: 1 ☐ Inpatient 2	ER/Outpatient 3	□ DOA	Other:	□ Nursing H	ome 5 Residence	6 ☐Other (Sp	ecify)		
27. Manner of Death 1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	ig gation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		c. Injury at Work? 1 □ Yes	2 □No	28d. Describe how in	jury occurred			
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						8f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1	ng Physic Examine	cian: To the best of my kno r: On the basis of examina and manner stated.	wledge, death occ tion and/or investi	urred at gation, i	t the time, on my opinion	late and place on, death occu	e, and due to the cause rred at the time, date a	e(s) and manner and place, and du	as stated. ie to the caus	se(s)	

29c. License number

100 Brown St. Chastortown MD 21620

29d. Date signed (Month, Day, Year) 15/2016

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Deil Stoddord MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and No. 11/19/State Amend Items 23aPtII,27,28a-f per me,g909,11/19/Certificate of Death	lental Hyg 2010dhb R	iene _{eg. No} 2010	36433
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
	Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	11	4c. County of Dea	
-1			University of Moralud Medical Conter Baltimore		N	/A
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign ountry)
and	show	JO.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mary	28a-f otifie	Director	MD Baltimore Baltimore			1 🗆 Yes 2 🕽 No
h with the	ns 23a or nust be r	Funeral C	10e. Street and Number 10f. Zip Code 21207	1	0g. Citizen of What C	country?
land 21215-0036 be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ò	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates.	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
21215-0036 within 72 hours after	giene. ner than "nat t, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 15. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NOT use retired) 16. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NOT use retired) 16. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NOT use retired)	ng	16b. Kind of Business Reta	•
Maryland 2	Vental Hyg arked othe tic event,	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	,	
e, Mary and 2 should	ealth and Mental H n 27 is marked o ier traumatic eve		19a. Informant's Name/Relationship (Type, Print) Lieva Lashaun Sinith Daughter 3506 Trains Avenue			
Baltimore, permit. Page 1 and	ment of He tant: If iter jury or oth		1 Removal from State Cemetery, crematory or other place) 4 Donation 5 Other (Specify)	- 2010	20c. Location - City o Woodlaw	n, MD
Balt permit.	Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Value 8728 Liberty Road	Prainda	Wotown Mi	ray Services 21133
	ysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multis tem Or an failure Due to (or as a consequent of):	r respiratory arres	t,	Approximate Interval Between Onset and Death
	Medical xaminer	L.	Due to (or as a consequent 3 f): Sequentially list conditions, b.			
panted	nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Co. Intra abdovaius Infection	m May	1 MD	
60 ate be exe	physician and s the burial-transit	edical E	resulting in death) Last Due to (or as a consequence of): d	WAPPROVED BY M	EDICAL EXAMINATION	
687 ertificat	ding pt	/Mec	IF FEMALE:			
. Box (within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 1 Other (specify)		23d. Date of de Month	elivery Day Year
S, P.O. ires that the	signed by d be deta	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
ord w requ	s been shoul	plete	hysteroctomy 7/1/10 = postoperative complications, Bilateral Ureter Injury	24a. Was an	24b. Were au	utopsy findings available
Hec The la	ate ha	Com		autopsy perform 1 Yes 2	ed? death?	completion of cause of
Ital	certific rector,	Be	25. Was case referred to medical examiner? 1. Yes 2 □ No Hospital: 1. Greating a □ FR (Others) a □ Dot Other:			
ot V	eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 2		ce 6 Other (Spectrology) occurred U	
ION (leath. or: Afte the fun	Certificate:	2 M Accident Investigation 7/1/10 Unknown 1 ☐ Yes 2 M No	transect procedur	ed during	surgical
DIVISION OF VITAL RECORDS, tal or Attending Physician: The law requires	irs after or al Direct led in by		4 Useriaida determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre City or Town, Medical	et and Number or Ru State) Greate Center, Ba	ral Route Number, r Baltimore Ltimore,MD
the Hospi	the Funer	Medical	29a. Certifier (Check only one) 1—Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and of each occurred at the time, date and place, and only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place and place.	the time, date and	place, and due to the	cause(s) and manner stated.
	10		29b. Signature and title of certifier 29c. License number 2 1255	29	d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura Ducha and 22 5. Greene St 31. Date filed (Month, Day, Year) NOV 19 2010 A part of the second sec	Baltin	me m	D
	Stat Registra	-	NOV 1 9 2010 32/Registrar's Signature Aparel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jovembe 17:31 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL BALTIMORE ENTER, If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
Sept. 4, 1931 Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 🗆 F Months Days 236-44-8438 Director 79 MD Usual Residence of Decedent ems 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Funeral Director 10c, City, Town or Location 10d. Inside City Limits MD Baltimore 1 Tes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7921 Baltimore Street 21224 USA ıral", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operator Baltimore 10±h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John H. Shupp Bessie Sue Hartley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma L. Shupp /wife Baltimore Street Balto. MD 21224 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Cemetery 11/19/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardiopulmonary disease or condition hou Medical resulting in death) Due to (or as a consequence of): Examiner neumonia Sequentially list conditions Examiner to for at a controquence of, if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year pate has been signed by the spage 2 should be detached g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? **Director:** After this certificated in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

4940

PARK

MINKYUNG

M.D.

Eastern Avenue Baltimore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edmund Warren Schiemer NOV 2010 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Min. Hours 1 X M 2 □ F Months Davs 88 Director 216-16-2040 AUG 6, 1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Modical Examinational societied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Exactiver must be notified at Director MDHoward Laure1 1 □Yes 2**X** No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8544 Pineway Court 20723 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Mechanical Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Michael Schiemer မ 01ga Heft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Schiemer, niece 8544 Pineway Court Laurel. MD20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or ot 1 ☐ Burial 2 📆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/18/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Sery 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.
neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 17 2010 D30989 ause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Maiden Choice In Oatonsville MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#12pexFH, G909, 11/30/2010 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ George Robert Scheflow 03:50 AM NOVEMBER Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT JOSEPH MEDICAL TOWSON CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours 86 Director 336-16-6093 Elgin, Nov. Illimis Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Ockeysville 1 Tes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 13801 York Road Apt M12 21030 United States items; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ٥ Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes, Give 1 ☐ Yes 2 √ No Specify: and Mental Hygiene. is marked other than "natural", Specify: 3 ★Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Bob Joos Equipment Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Scheflow Vera Sipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 strent of Health a tant: If item 27 is lury or other tra 16101 Baconfield Lane Monkton, Maryland 21111 Martha Spencer (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place; vans Funeral Chapel Evans 20 Forest Hill, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Monkton 16924 York Road Monkton, Maryland 21111 23a. Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) MYOCARDIAL INFARCTION Medical Due to for as a consequence of Examine CARDIOGENIC Sequentially list conditions. Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury ARTERY or Attending Physician: The law requires that the death certificate be executed ILIAC attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown Division of Vital Records, P.O. ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy director, page 2 certificate I Yes 2 1 Yes 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Be 26. Place of Death (Check only one) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND KHOSROW TABASSI MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

10-08545 Charlene Sellner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

narierie Seilner		1- For State State of Maryland / Department Certificate			g. No. 2010	3643
Physicia Medical Examiı		Decedent's Name (First, Middle,Last) Charlene M. Sellner		2. Date of Death Month November		3. Time of Death 0300 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	_	4c. County of Death	
T		2308 57th Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Cheverly	- Io Data of Birds	Prince George	
Funeral Director) If Under 1 Year If Under 24Hr Months Days Hours Mi Yrs.			thplace (State or Foreign untry) shington, D
any		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
Aaryland 28a-f show	ō	Maryland Prince George's Tuxed	0			1 Yes 2 X No
or 28a-	Director	10e. Street and Number 6200 Tuxedo Road	10f. Zip Code	10	g. Citizen of What Cour	
eath with the Maryland items 23a or 28a-f sho			20785 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	United Sta	can Indian, Black,
MD 21215-0036 A 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene. To smarked other than "natural", or items 23a or 28a-f sh aumatic event, the Medical Examiner must be notified at once	Funeral	1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	White, etc.	
irs after ural",	٦	for Dates:	Yes 2 X No specify: dent's Usual Occupation (Give kind of	work done	Specify: Who	
72 hou n "nat	Completed		g most of working life. DO NOT use re		Tob. Tand of Basinessin	riddoll y
003(within giene. her tha	dwo	10 17. Father's Name (First, Middle, Last)	Unemployed		n/a	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Harry Milton Sellner	18. Mother's Nam	e (First, Middle, M	vce Yost	
D 2121 should be fi and Mental 7 is marked	리	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or	Rural Route Numb	per, City or Town, State,	Zip Code)
nore, MD ages 1 and 2 sho nt of Health and nt: If item 27 is other traumati	-		Strauss Avenue	Marydel,	DE 19964 20c. Location - City or	Town State
nore ages 1 at of H at: If i		1 Burial 2 X Cremation 3 Removal from State crematory or	other place) rney Crematory 11	/12/2010		, Maryland
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ŀ		oling Home Cremati			
		23a. Fert I. Enter the disease, or complications that caused the death. Do not enter	everly L. Heckrot	te. P.A	Clarksvill	Le, MD 2102
Physician \/Medical	ı	failure. List only one cause on each line.		or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	ē	sequentially list conditions, if any leading to him edicte b. Gastroesophageal of the form of the for	rosion			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last underlying in the control of the Country of	liver			
cuted ind transit	ă	Stories residing in deathy East				
60, ate be executed obysician and re burial - transit	gigi	AMENDED PI line a-c, 2	7, per ME g909 11	/30/10 T		
x 68760, o certificate be executed ending physician and use as the burial - transit	Ž	23b Was decedent pregnant in the	Fetal death 3 Ectopic pregna		23d. Date of delivery	ay Year
Box 6876 e death certificat the attending ph ed for use as the	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)			
the o		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
S, P.O.	ğ b			1 Yes	2 No 3 Proba	ably 4 Unknown
Division of Vital Records, ra der death. In or Attending Physician: The law requires after death. In Director: After this certificate has been a led in by the funeral director, page 2 should be.	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
tal Rec	S			perform	ned? death? ☐ No 1 ✓ Yes	2 No
/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Check		esidence 6 🗸 Other:	Scene
ing Ph	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Month, Day, Year)		28d. Describe ho	w injury occurred	
Sion Attend death. ector:	läi.	2 Accident Investigation	1 Yes 2 No	2001		
Divis pital or At ours after d ceral Direct filled in by	ertification:	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	or Town, Sta	eet and Number or Run te)	al Route Number, City
by fi	아	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ				
To th within To th	교 L	 one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. 29b. Signature and title of certifier 	29c. License number		and place, and due to the 29d. Date signed (Mon.	
	-	Carol HAODav	O.C.M.E.		November 8, 201	
	-	30. Name and address of person who completed cause of death (Item 23a)				
2/			Street, Baltimore, MD 2120	1		
Sta Registr	ar	31. Date filed (Month, Day Year) 32. Registrar's Signature	w.			

			1 = For State Registrar	State of Ma	aryland		artment of F tificate of		ا Mental Hy ا	giene Reg. No.	JIU	56430
		п	Decedent's Name (First, Middle, L.)	ast)					2. Date of Dea	ath	Vere	3. Time of Death
П	Physici /Medic		Sarah Jeannette	Tressler					Novembe	r 16,	, 20 ^{Year}	7:30 P M
п	Examin		4a. Facility Name (If not institution, ga				4b. City, Town, o	r Location of Dea	4c. C	4c. County of Death		
			Maryland Presbyte				Towson				altimore	
	Funeral Director		5. Social Security Number 6. 215-20-5027	Sex 7.Ag 1 ☐ M 2 ☐ XF	e (In yrs. la 87	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min		h y, Year) 3	9. Birthpl Coun Mary	
	P		Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	arylar show	<u></u>	10a. State 10b. County Maryland Baltimo	ro	Tow:	, Town or Lo	cation				10	0d. Inside City Limits 1 ☐ Yes 2 🕱 No
	he M	Director			1 OW	3011	1			10 011	(111)	
	a or	Dir	10e. Street and Number 400 Georgia Cour	+ # 67			10f. Zip Code 21204			U.S.	en of What Coun	try?
	leath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V		lispanic Origin?	(Specify Yes or No-		4. Race - America	an Indian.
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Itams 23a or 28a-1 show avent. I'n Modical Ezatrata Lubil Le indiffied at	by	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			f Yes, specify Cuba I ☐ Yes 2 🕱 No	an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		Black, White, 6 Specify: Whit	etc.
ر ک	72 ho natur iical	eted	15. Decedent's ! (Specify only highest g			16a. Deced	lent's Usual Occup	ation	vorkina		d of Business/Ind	,
7	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done OO NOT use retired	d)	oming .		timore C	•
7.	filled w Hygiel thar tl	S	17. Father's Name (First, Middle, Las	5-	F	Teac	ner	18 Mother's N	ame (First, Middle,		lic Scho	015
an		o Be	Eugene F. Raphel	•/					A. Cherbo		,	
Maryland 21215-0036	S B E E	Ţ	19a. Informant's Name/Relationship					and Number or I	Rural Route Numbe	r, City or	Town, State, Zip	
	ss 1 and 2 of Health a item 27 ls othar tree		John Joseph Raph	el Tresslem		A CONTRACTOR OF THE PARTY OF TH		nd Road	Baltimor			
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		Ce	metery, cren	sition (Name of natory or other place erv. Cor		Date /18/2010		ation - City or To	
# E	mit. Partme		21. Signature of Fundral Service Lice						ick Towso			
ñ	P P P P P P P P P P P P P P P P P P P		N/ Vella	111/1		10	50 York	Road Tow	vson, Mar	yland	21204	
			23a. Part1. Enter the disease, or con shock, or heart failure. List ont	/ one cause on each li	10.			_				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Nor	1-5~	igll ce	11 Carc	mone c	of the	441		bissially beautiful.
	/Medical Examiner		Tooking in doubly	Due to (or as	a consequ	ence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):						
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	6								
Ď,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):						
08/60	icate b physic s the b	edical		d								
	eath certifi attending I for use as	ian/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icy				23	3d. Date of delive	rv
DOX	The law requires that the death certi te has been signed by the attending age 2 should be detached for use a	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1□Live birth 4□Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	′				Day Year
5	that the de ned by the a detached f	Physici	9 🗌 Unknown	9□ Unknown								
	w requires that s been signed k s should be det	by F	Part II. Other significant conditions	contributing to death b		Iting in the ur	nderlying cause giv	en in Part I.				e cause of death?
0	requil	eted		V 3 / 1 / 1	110	9. 2-4	7/7266	-/	- 1 1	′es 2□	No 3 Proba	ably 4 Unknown
Vital Records	The law cate has b page 2 sl	Completed	asthur						24a. Was autop		24b. Were autop prior to con death?	osy findings available npletion of cause of
<u>_</u>									1 ☐ Yes	2) E -No	1 Yes	2.2No
	Physician: this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		R/Outpatien	t 3 DOA Oth	00	eath (Check only o		Cother (Cassife	a
0	ding Phys h. After this funeral dir	-	27. Manner of Death	28a. Date of Inju	ry :	28b. Time of	28c. Injur		Home 5 Resid)
0	anding ath. or: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		/ rear/	Injury		Yes 2 ☐ No				
DIVISION	To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Could not determined				eet, factory, office		28f. Location (S City or Tox		Number or Rura	Route Number,
_	ospita hours uneral y filled		29a. Certifier 1 Certifying P	hysician: To the best	of my know	vledge, death	occurred at the tin	ne, date and pla	ce, and due to the	cause(s) a	ind manner as st	ated.
	the Hin 24 the Fit	Medical	one)	miner: On the basis of and manner sta	examination	on and/or inv						
	To To con	Σ	29b. Signature and title of certifier	- 12M			29c. Licens	e number		Zed. Date	signed (Month, L	20/0
			20 Name and address of a second	MATE	and dis-	00-1/5	Dates)	1 - 16		255	11/	55:
			20. Name and address of person who Keshah M. Gree	4e, mo 6	701	N. (4	les St., S.	c.fe 410	4 Boltin	non	mb 2	1204
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 9 201	32. Registra	ar's Signati	bark				ţ		
			110 7 0	N-A-	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Day Month Year **Physician** 2:37PM NOVember 15 Nathan Terry Jr. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba HIMOVC 7. Age (In yrs. last birthday) Saltmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Hours Min. 1**√** M 2□ F Days Director 67 216-42-4554 07 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maclical Examinar must be notified at once. 28a-f show Director 1 XYes 2 No MT) NA Baltimore 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 21215

13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2506 Ouantico Ave U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 1 Never Married Married 2 No 1 ☐Yes 21☑No Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> Ship Fitter Beth Steel Corp. na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Terry Sr. ည Ethel Mae Carrol 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Terry-Wife 1506 Quantico Ave, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 11/22/2010 Baltimore, Md 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDINI day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 DARKINSONS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No almana 24a. Was an autopsy this certificate by all director, page ementia Vital 2 110 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA of Certification: To : After thi 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner tated. 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and

trancis 31. Date filed (Month, Day,

NOV

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Year

ess of person who completed cause of death (Item 23a) (Type, Print) conut

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 17 State of Maryland / Department of Health and Mental Hygiene / Per fn, 8909, 11, 19/2010dhb State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Angela Gerda Thompson 4;23 PM 11 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Rosedala Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Min. (Month, Day, Year) Sept. 20, 1934 Germany Director 230-58-3047 76 Yrs Usual Residence of Decedent 10a. State 10b. County IId be filed within 72 hours after death with the Maryland Mental Hygiene. ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 😾 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 419 North Streeper Street 21224 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter dical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ₩ Widowed 4 Divorced white Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sabatinos Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be -UNIKNOWN Xaver Toth Kunigunde Guth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Thompson-son 419 North Streeper Street-Baltimore, Maryland 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evans Funeral Chapel and Nov.19,2010 Forest Hill, Maryland Cremetica Sor Bolair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Ser. endral h.MS. 8800 Harford Road-Parkville,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Fatal Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) heart diease ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Atherosclerotic Coronary Due to (or as a consequence of): resulting in death) Last Physician/Medical a Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) • Hospital or Attending Pl 24 hours after death. • Funeral Director, After the 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR Balto 21237 PR michael B. Pipkin 31. Date filed (Month, Day, Year) State

✓ DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sevim Soysal Turek 17,2010 November 7:40 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year)
June 02, 1931 1 □ M 2 🎛 F Months Days Hours Min **Director** 212-46-0652 79 Akhisar, Turkey Usual Besidence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits N/A 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 4100 North Charles Street Apt. 1001 21218 United States or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Specify: "natural", 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 04 Attorney General Law and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ M. Emin Soysal Ayse Soysal i. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ibrahim Turek, M.D. (Husband) 4100 North Charles Street Baltimore, MD. 21218 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State (Harford Co.) cemetery, crematory or other place)

Evans Fure al. Unatel and
Cremation Services, Inc. 1 Burial 2 **Cremation 3 **Removal from State Thursday 4 ☐ Donation 5 ☐ Other (Specify) Nov. 18,2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peaceful Alternatives Funeral & Cremation Center, P.A. Jav. Blic. #100677 Timonium, Maryland 2325 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) METUSTATIC Pancreutic nth Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 1 Yes 2 Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant a g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has b page 2 sl autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \triangle Other (Specify) \square \square \square \square Hospital: 2 🕅 No 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

harles

MD

32. Regist ar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

70

70636

bultmore, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1357 M Ethel November 16 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 216-34 185 vland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 12. Was Decedent Ever in U.S. Apt 103
Armed Forces?

1 Yes 2 100
If Yes, Give U.SA 201 N. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ASSOCIATED CONTINL 12 Charities 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unknown Smith Annie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pocetimine MD Caton Ave 21220 Elaine Dungh 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ST. Stanislaus Duncialk, mD NOV 20,2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility GRAYSON Fineral SPIVICE Hitton Pass. Partinge 1 MD 21224 mald A. Braycan

Physician /Medical **Examiner**

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s been sign

page

funeral director,

24 hours after death. Funeral Director: Al filled in by the

To the Hospitai within 24 hor To the Fune completely fi

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

or 28a-f show notified at

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Maconce.

Funeral Director

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the death. Do not enter the recause on each line.	node of dying, such as cardiac or	respiratory arrest,		proximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	C.F		-	Onset and Death				
lical Examiner	Sequentially list conditions, if any, leading to immediate cause. List the defining Cause (Disease or injury that initiated events resulting in death) Last	b								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1	ic pregnancy (specify)		23d. Date of deli Month	very Day Year				
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I. 1 Yes 2 Divided 3 Price Part II.									
Completed by				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 \(\square\$ No				
Be (25. Was case referred to medical		26. Place of Death (Check only one)						
TO B	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	lospital: 1 Inpatient 2 ER/Outpatient 3 E	DOA Other: 4 Nursing Home	5 Residence	6 ☐ Other (Spec	ify)				
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		d. Describe how inj						
edical Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, fac building, etc. (Specify)	tory, office 28	3f. Location (Street City or Town, Stat		iral Route Number,				
dical (ician: To the best of my knowledge, death occur ner: On the basis of examination and/or investiga and manner stated.								
Te	OOL Cinceture and title of portifier		20a License number	204 [ata signad (Month	Day Vear)				

RES-000

2010

November 16

600 North Wolfe St, Baltimore, MD, 21287

State Registrar Rod

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kahimi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death washington Physician/ Month Ethe lean Year 8:45 PM November ZOID Medical 4a. Facility Name (if not institution, give street and number **Examiner** n, or Location of Death 4c. County of Death Hospice & NW Hospital Randallstown Seasons Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD 28a-f Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Avunah items 23a 2305 12 Was Decedent Ever in U.S. Was Deceue... Armed Forces? Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black "natural", Specify: 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) aurel Kace Elementary/Seconday (0-12) College (1-4 or 5+) ttostess 11 th grade N Be 17. Father's Name (Pirst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental and Mental ဂ္ Frank Williams ula Stewart permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic in ene. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Hart Niece 7 Hiahburu Court Randallstewn MD 21133 Lyma Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 23/2010 Arbutus Memorial Park u Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funera Service Licensee 22. Name and Address of Facility Vaughor C. Greene Funeral Services Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End-stage Dementia Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of, resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 I Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at I Director: After the in by the funeral 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours and To the Funeral Dir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certi∮ie 29d. Date signed (Month, Day, Year) ASRAJAPANIM.O D0057465 11/18/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S.Ra(AMX)** 2835 Smith AV- S-203-Baltimore, MD. 21209 N. S. Rajapakse, M.D 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Weems **Physician** 11: 52 PM 16 November 2010 Varie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 M 2 F Aug 24, 1941 Maryland 69 216-36-4596 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 No Baltimore Director N/A Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21217 U.S.A. 604 School Street items 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: Black 2 3 ¥Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical within 72 (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) State Of Maryland Claimant : 1 and 2 should be filed w ! Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be Annie L. Greene Grover Campbell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is m any injury or other 5309 Mayview Avenue Baltimore, Maryland 21206 Claretha Smith Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 XCremation 3 Removal from State Catonsville, Maryland 11/20/10 Metro Crematory, Inc. 4 Donation 5. Other (Specify) 21. Signature of Fineral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Enter the disease, or complications that caused the complete or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -Physician gastrointestina /Medical Tue to (or as a consequence of) Examiner Sequentially list conditions, if any local trimm Jalicause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of death certificate be executed use as the burial-trai resulting in death) Last Due to (or as a consequence of) physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) P.O. the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown cirrhosis Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 WO 1 Yes 1 Inpatient 2 ER/Outpatient 3 🗌 DOA P the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 Accident 24 hours after death. Funeral Director: A 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Hospitai 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 November 17 se of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Gladys Wilson 4:27 AM 106 Medical ovembe. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center of Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖬 F Months Hours Min Yrs Director 219-28-5087 Sep 26, 1924 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shaw any injury or other traumatic event than "the status". 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 🗡 Yes 2 🗌 No Baltimore Maryland **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1105 Lyndhurst Street 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Department Secretary 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) မ Gladys Brown Benjamin B. Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 Sequoia Avenue Baltimore, Maryland 21215 Louvenia Swinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/18/10 Baltimore, Maryland Arbutus Memorial Park 21. Si 1 Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P 23a Part 1. Enter the disease, or complications that caused tipe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ percapreic Medical Due to (or s a consequence of): Examiner Interstitio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for I in the past 12 months? 1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 XNo 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 XInpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State)

Box 68760 P.O. Division of Vital Records,

> State Registrar

Medical

29a, Certifier

Chery

31. Date filed (Month, Day, Year)

NOV 1 9 2010

only one) 29b. Signature

DHMH 17 Rev 7/2009

South Greene

MD

32. Registrar's Signature

DD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

067594

Baltimore

29d. Date signed (Month. Day, Year) November 14,2010

29c, License number

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201°Ö $6:40 \ a_{M}$ 16 Weldon Nena Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Balto 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F Hours Min. 12-13-1958 219-70-5439 Director 51 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 817 E. 22nd Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Record Chevy Chase Bank Tech 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Martin Weldon Ella Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22nd Street Balto, MD 21218 George Lilly -Husband Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 11-19-10 Arbutus Memorial Arbutus, 21, Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE . If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 No Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performe Director: After this certificate Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Spec Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 \square Pending Accident

3 Suicide

4 Homicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fraction of T. the basis of my in which you destined at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mor Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:14 PM Lorraine Catherine Whitmore VOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min 07/17/17/1927 Director 219-22-8635 Marvland Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Baltimore Fork 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 12700 Fork Road 21051 U.S.A. hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene
7 is marked other the 10 Cook High School Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fit thent of Health and Mental tant: If item 27 is marked olury or other traumatic ew 2 Charles D. Amrein Anna Marian Hurline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other t Laurie A. Short (daughter) 375 Wimbleton Way - Red Lion, Pennsylvania 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Luth Ch.Cem. 11/20/2010 | Long Green, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. A. 6. assa 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition Medical resulting in death) **Examiner** ADENOCARCINOMA LEFT LUNG Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a thed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACUTE RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Natural 2 Accident 3 Suicide Investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar mix

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER

7601

32. Registrar's Signature

D24034

DRIVE TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16 Day Ann Mildred Woods Wilson 2010 Nov. 5:00 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2609-A Putty Hill Avenue Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country: Maryland . Age (In yrs. last birthday) **Funeral** 8. Date of Birth Year) 1925 1 □ M 2 🛣 Min Apr. 18, 219-16-4798 **Director** 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Les mould be filed within 72 hours after death with Health and Mental Hygiene.

9m 27 is marked other than "nah..."

her traumatic even" 2609A Putty Hill Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant **WYCA** Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ottany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Joseph Woods Rose Myrtle Reely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Seibert / Daughter 8521A Old Harford Rd., Parkville, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 11/17/2010 | Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Cremation Society of Maryland orge MacNabb <u>Frederick Rd., Baltimore, MD 21228</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. neet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery been signed by the atte should be detached for in the past 12 months?
1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D4460 of person who completed cause of death (Item 23a) (Type, Print) Parkulle MD 8109 t 2123

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Day

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AMEND ITEM#12perFH.G909.11/30/2010, WS
State of Maryland Department of Jeann and Wental Hygiene
AMEND TIEM#12perFH.G918,8/16/2011, WS 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 352 AM Earl Wise Jr. November 2010 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 5, 1954 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1**∑**M 2□ F 235-84-7444 56 Martinsburg.W Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at MD Baltimore 1 XYes 2 No Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3500 ODonnell Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes - 32-11-15 If Yes, Give 5/25/197 Year or Dates: 5/22/18 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 25/1972-5/22/1978 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. HMI Elementary/Secondary (0-12) College (1-4or 5+) Installation Mechanic 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl W. Wise, Sr. Peggy Hess other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 3500 ODonnell Street, Baltimore, MD 21224 Robin Brown/ Fiance 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition November emetery, crematory or other place)
Evans Funeral 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 20,2010 Forest Hill, Maryland injury o Chapel-Bel Air 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any in once. Evans Funeral Chapel & Cremation 8800 Harford Road, Parkville, MD Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. medi te Cause (Final dea or condition ASCVO **Physician** long standing d ear or condition remaining in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 🔲 Inpatient 2 X ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P-0061115 2010 November 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4440 Eastern Avenue Pantle Baltimore, Maryland Hardin MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 19 ZUIU Registrar

DHMH 17 Rev 1/2001

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1- State Registrar Amend Items 28a-f per me,g909,11,19/2010dhb
Reg. No.

Reg. No. Reg. No. U 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 08.44AM **Physician** Patricia Ann Wolford November 08 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St Agnes Hospital

5. Social Security Number 6. Sex Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2(XF Months Days Hours 67 Director 215-40-0802 Sept 30, 1943 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show event, the Medical Evaminer must be notified at Director 1 ☐ Yes 2☐ No Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code items 23a 3475 Marble Arch Drive USA Funeral 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 □Yes XX No If Yes, Give Year or Dates: Specify White 2 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, its May once. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor BWI Maryland Parking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelson Crawford Pearce Estella Irene Wright ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Michele Grim / Daughter 1152 Annis Squam Harbour Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 11/13/2010 | Glen Burnie, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Complications 24 hours disease or condition resulting in death) /Medical 3 days Due to (r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY WE JICAL EXAMINER Examine sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Aneurysm 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary artery 24a. Was an autopsy performed?

1 □ Yes 2 □ No Renal artery stenosis 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred Vena cava injury during aortic bifemoral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 11/05/2010 1 ☐ Yes 2 X No 2 Accident Unknown M after death bypass surgery 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 900 S. Caton Ave. 4 Homicide Hospital Baltimore, MD Funera Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 AS24385224348 08 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) caton Baltimore, 900 S Hani Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Martha Lydia Willis Month 2010 10AM MSVO Medical 4a. Facility Name (if pot institution, give street and number) Examiner 4b. City, Town, or Location of Death SNOT timore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min 90 Nov 28, Year919 293-09-9874 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 **USA** 709 Maiden Choice Lane CCS 331 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Nellie Catherine Ayers Charles Fay Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James B. Willis, Jr., Son 42318 Park Circle Drive Polson, MT 59860 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 11/17/10 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ear Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectonic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 HNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d address of person

Registrar

State

31. Date filed (Month, Day Year) NOV 1 9 2010

who completed cause of death (Item 23a) (Type, Print)

			Please	State of Maryland				•	0011	36452			
			1 - For State Registrar	State of Maryland		rtificate of				0 00702			
	-		Hegistrar Decedent's Name (First, Middle, Last	st)		timodito or i	Douti.	2. Date of De	Reg. No.	3. Time of Death			
	Physici		Sue-Yun	Ying				Month	er 5, 201	ear 0 9:50 PMM			
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of				
	Examin	let	3600 Cherryval			Beltsv			Prince	George's			
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th g	Birthplace (State or Foreign Country)			
п	Director		214-86-5177	^{1□ M 2} √ F 101	Yrs.	Months Days	Hours Min.	Nov. 2	6, 1908	Couintry) China			
	pr ,		Usual Residence of Decedent	140-00	. Town or Lo	tion				10d Inside Ohulimite			
	arylar show d at	-	10a. State 10b. County							10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	Ba-f	Director	Maryland Prince (George's Bel	tsvil				10- 011				
	with the part of t		10e. Street and Number	4		10f. Zip Code			10g. Citizen of Wh	at Country?			
	sath is 23a	Funeral	3600 Cherryvale Di	rive 12. Was Decedent Ever in U.S	3 13	20705		pecify Ves or No	U.S.A.	American Indian,			
	ter d	E.	11. Marital Status 1 ☐ Never Married 2☐ Married	Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.			
336	urs ai	Ş	3 X Widowed 4 Divorced	1		1 □ Yes 2 🗓 No	Specify:		Specify:	Chinese			
0-0	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's Ed (Specify only highest gra	ducation (16a. Dece	dent's Usual Occup	pation	kina	16b. Kind of Busi	ness/Industry			
215	e. an "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)	wig					
21	filed within Hygiene. ther than " tnt, the Med	Completed	12		Ho	memaker			Own Ho				
pu	tal H d oth even	Be	17. Father's Name (First, Middle, Last,)					, Maiden Surname)				
yla	12 should be filed within h and Mental Hygiene. 7 Is marked other than traumatic event, the Me	10a. State 10b. County 10c. City, Town or Location 10c. City Code 10c. City Town or Location 10c. City Code 10c. City Code											
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (ng Address (<i>Street</i> inisterra		e, CA 9:		rate, Zip Code)			
	1 and 2 Health tem 27 I		Spencer Ying (Son 20a. Method of Disposition			sition (Name of matory or other place		Date Date	20c. Location - Ci	ity or Town, State			
0			1 Burial 2 □ Cremation 3 □ 4 □ Dopatton 5 □ Other (Specification)	Juellioval Ilolli State		matory or other plac s Mem. Pa	1	20/2010	Whittie	r CA			
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice		2	2. Name and Addre	ss of Facility						
B	Dep Imp any		1 L bund In	Mun	R 3	ose Hills 888 South	Mortuar Workman	y Mill R	d., Whitt	ier, CA 90601			
	3.1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation of the mode of dying, such as cardiac or respiratory arrest, interval Bronset and the mode of dying, such as cardiac or respiratory arrest, or heart failure.										
	Physician		Immediate Cause (Final disease or condition	a Hypertension						Onset and Death 25 Years			
	/Medical		resulting in death)	Due to (or as a consequ									
	Examiner		Sequentially list conditions,	b. Osteoarthrit						25 Years			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	,					25 Years			
	and al-trar	xan	that initiated events resulting in death) Last	c. Osteoporosis Due to (or as a consequ						25 Teals			
760,	sician buris	Sal		Cholelithia	sis								
68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit			Ed.									
Вох	h cerr	N/	iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar		∃Ectopic pregnanc	14		23d. Date				
	death	Sicis	in the past 12 months? 1 ☐ Yes 2 █ No	4☐ Pregnant at time of de		Other (specify)	,		Mont	h Day Year			
P.0	at the de i by the a stached	Physician/Medi	9 Unknown		net		t. B. at	00 - Did	A-b	ute to the cause of death?			
	ires tha signed l	ð	Part il. Other significant conditions of Abnormal Liver F		iting in the u	ridenying cause giv	ven in Fait I.			□ Probably 4 □Unknown			
Ö	w requir been si should t	eted											
or Vital Records,	has has by	Completed	Dementia					24a. Was	posv pri	ere autopsy findings available or to completion of cause of ath?			
a			25. Was case referred to medical						2 🖾 No	Tyes 2□ No			
⋚		o Be	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐ I	EB/Outnatie	ot 3 DOA Oth	26. Place of Dea		o <i>ne)</i> idence 6 □Other	(Snacifu)			
ō	y Physer this eral di	7: To	27. Manner of Death	28a. Date of Injury	28b. Time o				how injury occurred				
ion	nding F tth. r: After e funera	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2□No						
Division	or Attending itter death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			reet, factory, office			(Street and Number	or Rural Route Number,			
	Ital on rs after all Di	Cert											
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exam	hysician: To the best of my know miner: On the basis of examinat	wledge, deat ion and/or ir	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the erred at the time	e cause(s) and man e, date and place, ar	ner as stated. nd due to the cause(s)			
	To the within 2 To the comple	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)			
	F≥F8) un			03	4722		11-00				
/			38. Name and address of person who	completed cause of death (Item	23a) (Type.		. / -		71 00				
		1	Vicken Poo Chik				Dr. #A B	Berwyn H	leights, N	1D 20740			
	Sta	ate		32. Registrar's Signat	ture								
L	Registi	rar	NOV 1 9 2010 X	known > p. 190	West of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	of Marylan	d / Depa <i>Cei</i>	artment of I	lealth ar Death	nd Men		ene) (3	364	53
		4	Decedent's Name (First, Middle,	Last)						Date of Death			3. Time o	f Death
	Physici /Medi		Joseph Yancey,	Sr.						11/16	5/2010	Year	4:50	РМ
	Examir		4a. Facility Name (If not institution,		mber)		4b. City, Town,	or Location of I	Death		4c. County o	f Death		
			Washington Adv	entist H	ospital		Takom	a Park			Montgomery			
	Funeral			. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. E	Date of Birth		9. Birthpla	ace (State	or Foreign
п	Director		232-40-1729	1 X M 2□F	82	Yrs.	MOTHETS Days	Hours	IVIAI.	Date of Birth Month, Day, 1 7/9/192	28	Count	PA	
	p v		Usual Residence of Decedent 10a. State 10b. County		too Cib	Town and								
	anyla ehov	-				, Town or Lo						10	d. Inside C	ity Limits 2. 2. No
	Ne M	ecto	WV Berk	ley]	Hedges								245140
	with t	Director	10e. Street and Number				10f. Zip Code			109	g. Citizen of Wi	nat Count	ry?	
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ထ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Ptygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show sayl injury or other traumatic event, I'm Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 Marrie	Armed Fo d 1 X Yes	orces? 2 🔲 No		Was Decedent of I		Puerto Rica	n, etc.)	14. Race Black	, White, e		
21215-0036	ral', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gr Year or D	ve _{lates:} Korea		1 ☐ Yes 2NNo	Specify:			Specify:	Whi	.te	
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3	ould Mer Marke Marke	ဥ	Philip Yancey						:le Mo					
Nar	12 sh and rie m		19a. Informant's Name/Relationship				ng Address (Street					tate, Zip (Code)	
	1 and Health		Pat M. Yancey/ 20a. Method of Disposition	Wife	20h B		Cabin Dr	., Hed	esvil Date			Na Ta.	C1-1-	
JO.	ges if of h		1 ☐ Burial 2 ☐ Cremation 3			emetery, crer	natory or other pla	,			Oc. Location - C	ity or Lov	vn, State	
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5	30		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that of	aused the death								Approxima Interval Be	te
	Physician		Immediate Cause (Final	1-				200	· . Lern		D0-		Onset and	Death
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9		Med	IF FEMALE:									- 17		
Box	eath certifi attending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1☐Live b	tcome of pregnar pirth 2 Fetal	death 3	Ectopic pregnanc	у			23d. Date Mont		,	Year
0	The law requires that the death certifule has been signed by the attending rage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□ Unkn	nant at time of de own	eath 5L	Other (specify) _							
Q	that ti	Ph	Part II. Other significant condition	s contributing to d	eath but not resu	liting in the u	nderlying cause on	en in Part I		23a. Did toba	cco use contrib	oute to the	cause of o	death?
Records,	signe d be	1 by	Cepelinal un	-	NON	1.00	ephalopa					B ☐ Proba		Unknown
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	To the Hospital or Attending Physician: The law requir within 24 hours alter death. To the Funeral Director. After this certificate has been s completely filled in by the funeral director, page 2 should	edical (29a. Certifier Certifying (Check only one)	Physician: To the	asis of examinati	vledge, death ion and/or inv	n occurred at the tr restigation, in my	me, date and popinion, death	olace, and o	due to the cau t the time, date	se(s) and man	ner as sta	ted. the cause(s	;)
	ithin ; o the	Mec	29b. Signature and title of certifier	and man	ner stated.		29c. Licens				d. Date signed			
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λ			30. Name and address of person wh	no completed com	e of death flor	23a) /Tuna	Print)	1 90	0		Overb	RAT	1,20	110
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1	કુ ^{ુંહ} Sta	te	31. Date filed (Month, Day, Year)	T _a	egistrar's Signat	ure				· Y 111.	4.417.	T N		8
16	Registr	ar	MOV 4 @ 2010	1 /2		As a. W								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day ROBERT P. ZAPF, SR. NOVEMBER 10:30 P 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE Social Security Number Age (In yrs, last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F (Month, Day, Year, 5/14/1922 MARYLAND Director 213-18-3807 88 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director BALTIMORE PERRY HALL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9530 OAKBRANCH WAY 21236 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Year or Dates. WWII Specify: WHITE "natural", 3 X Widowed 4 ☐ Divorced marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) SCHAEFER & Elementary/Seconday (0-12) 12TH GRADE uld be filed within 7 I Mental Hygiene. College (1-4 or 5+) SALESMAN STROHMINGER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PETER ZAPF MARGARET MARNIEN and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 short Health and Item 27 is r MARNIEN O'BRIEN/DAUGHTER 9530 OAKBRANCH WAY PERRY HALL, MD 21236 permit. Page 1 and Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 11/22/2010 EASTPOINT, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 502 8521 LOCH RAVEN BLVD. 21286 TOWSON, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Emysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending IF FFMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? O Month Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 1 Yes 2 No Records, P.O. s been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 4 Unknown 2 🔲 No 3 Probably Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 has autopsy perforn certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 (X)No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 6 Other (Specify) NO PIG Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day

NUA

C. G. Gara

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles ST

POLISON MO

			For Amend Item 2	25 per me, gydy	,11 /19 Cer	72010dhb tificate of L	Death	Re	eg. No.		
P	hysicia	าก	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al .	4a. Facility Name (If not institution, give	ise Angell		4h City Town or	Location of Death	10	4c. County of	of Death	07 13 KM
) E	xamin	er		edical Cente	^	Baltimo	_				
Fu	neral		Social Security Number 6. S	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthp Cour	place (State or Foreign ntry)
Dir	ector		569-80-6721 Usual Residence of Decedent		60 Yrs.			FEB.18	1950	CAL	IFORNIA
yland	MOU TH		10a. State 10b. County		y, Town or Lo	cation				1	0d. Inside City Limits
e Mar	Ba-1 S	Director	MD CHARLE	S	WALDOI						1 Yes 2 No
with th	a or 2 beng	Dire	10e. Street and Number 3339 JONATHAN	COURT		10f. Zip Code 2060	12	1	0g. Citizen of W U. S		
leath	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. \	Was Decedent of H		pecify Yes or No-	14. Race	e - Americ	can Indian,
-UU36 hours after death with the Maryland	d other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🔼 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2∑X lo If Yes, Give Year or Dates:	1		Specify:	Hican, etc.)	Specify.	k, White, i	etc. HITE
Maryland 21215-0036 d 2 should be filed within 72 hours aff tith and Mental Hyglene.	natura fical E	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of work		16b. Kind of Bu	siness/In	dustry
within 72 ene.	han :	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	1)				
filed v Hygie	other t		17. Father's Name (First, Middle, Last)	1	HOME	AKER	18. Mother's Nam	e (First, Middle, N	OWN H		
ld be Aental	marked other than matic event, Inc.M	To Be	ROY GEORGE BR	ERETON			MARY	FRANCES	S GREI	VE	
and N	item 27 is marke other traumatic		19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	; City or Town,	State, Zip	Code)
	m 27 her tr		STEVEN ANGELL/			JONATH			ORF , M		
Baltimore, permit. Pages 1 ar Department of Hea	= =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐	Removal from State	emetery, cren	sition (Name of natory or other place CREMAT	OCTO	BEK	GLEN B	-	
nit. Pe	Important: I any Injury o once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen								ICE, P.A.
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
Phys			Immediate Cause (Final disease or condition	a. Hypoxen	nia.						Onset and Deam
	dical niner		resulting in death)	Due to (or as a conseq		. /	N 11				l week
		Jer	Sequentially list conditions,	b. Hypoxemic	uence of	ratory T	Allure		- 1	vu)	
scuted	ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	c. Pulmonary Due to (or as a conseq	metas	tases		19	whelling	ER	1 Month
68760, tificate be executed	pnysician and the burial-transit		resulting in death) Last	Due to (or as a conseq. d. Gastric (uence of):	m. 100	+ c+ +'c 4	Van APPROVED EN	MEDICAL		3 months
68760 , ificate be ex	20 22	edical		d. <u>C/03177</u> 2	-MI LIVIO	101a, 101C	-2000	JOH MOKO			
	attending for use a	1000	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy	∃Ectopic pregnanc	GEK		23d. Dat	te of deliv	
I Records, P.O. Box The law requires that the death ce	the att	Completed by Physician/N	in the past 12 months? 1 □Yes 2 □No	4 Pregnant at time of a		Other (specify)			Мо	nth	Day Year
P. C	s been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions o	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use cont	ribute to t	the cause of death?
rds,	n sign	d by	Acute Kidney	_				1 □ Ye	es 2 No	3 ☐ Pro	bably 4 🗆 Unknown
S ME	s pee	olete	Severe Sepsis	5 1				24a. Was a	n 24b. 1	Were auto	opsy findings available
The la	ate ha oage 2	mo						autops perform 1 🗆 Yes	med2	death?	ompletion of cause of 2 No
/Ita	ertific ector, I	Be	25. Was case referred to medical examiner?	Hospital:		Tou		th (Check only on	ne)		*
O† Physi	this crail dire		1 X Yes 2 □ No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatier		4 🗀 Nursing n	ome 5 Reside			ífy)
ding .	: Affer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k? Yes 2 □No	Zod. Doddingo ik	ow injury docum		
Division of Vital Records, I or Attending Physician: The law requires the after death.	Director I in by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, str fy)	eet, factory, office		28f. Location (S. City or Town	treet and Numb n, State)	er or Rui	ral Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death.	e Funeral letely filler	Medical C	29a. Certifier (Check only one) Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti	me, date and place opinion, death occu	e, and due to the curred at the time, c	cause(s) and madate and place,	anner as and due	stated. to the cause(s)
To the within	comp	Me	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signe		
			D. Im				958967		10/4	/2	010
			30. Name and address of person who		n 23a) (Type,	Print)	20 ((0		AAA 212 A1
	Sta	te	Donald Harris, A 31. Date filed (Month, Day, Year)	32. Registrar's Signe	ept. of	Jungery, 2	14 J. GM	tene st,	1>=1+,~	٠٠, ١	ND 21401
	310		MIIV 1 8 9910	No and A	have	el. I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State AMEND#10eperINF, 11/12/10, BMW, McCo Certificate of Death 2. Date of Death Physician/ Month Vear 10 2010 11:12 MM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice Montgomer Montgomer Hockville If Und 6. Birthplace (State or Foreign Country) Puerto Rico If Under 1 Year 24 Hrs. **Funeral** 8. Date of Birth Hours Director 432-84-1824 25/1911 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e Street and Number 3430 Chiswick Court 10 10f. Zip Code 10q. Citizen of What Country? Funeral 23a Leisure World Blvd. 20906 U.S.A. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Joseph Griffith Frances Elizabeth Lutle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3445 S. Leisure World Blvd.. Silver Spring. MD20906 Mary Lynne Arthur-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) 11/06/2010 Silver Spring, MD Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Coronary Artery Diseas disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the buriat-liansit the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day Pregnant at time of death Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Right Ventricular Failure 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hupertension autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R143201

6001 Muncaster Mill Road, Rockville, Maryland 20850

October 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** James Thomas Abell, Jr. 2010 Nov. 20:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harrison Senior Living Snow Hill Worcester 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/20/1927 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 1 **X**M 2 □ F Days Hours Min Maryland Director 83 216–24–3818 Usual Residence of Decedent 10c. City, Town or Location 28a-f show 10a State 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Expriner must be notified as once. Director 1 ☐ Yes 2X No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2107 Holly Swamp Road 21851 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No 2 Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Merchant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Thomas Abell, Sr. Mary E. Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Abell, III (son) 2040 Holly Swamp Road, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Goodwill Cemetery 11/5/2010 Pocomoke City, MD 21. Sign stud of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one at hine. shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** auces /Medical Lue to (or as cor sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Linder in Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery The law requires that the death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 2 No signed by the a □Yes 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

Baltimore, Maryland 21215-0036

Box 68760.

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of Vital Records,

Division

State Registrar

31. Date filed (Month, Day, Year) NOV 0 4 2010

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29b. Signature and title of certifier

32. Registrar's Signature

6CPM

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2017 October Barwick 1:29 Рм De1ha Herrick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min 02-06-1944 New York Director 082-34-0719 66 Usual Residence of Decedent ra!", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Calvert Sololmons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 USA 13176 Windjammer Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black White etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 X Divorced Completed white event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ School Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard Herrick. Jr. Harriet G. Seibert Jav other traumatic and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Page 1 and 2 street of Health a sant; If item 27 is William Allen Barwick III. 13180 Windjammer Avenue, Solomons, MD son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/30/2010 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home. P.A. 4405 Broomes Is. Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) **Examiner** Toxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine quence of) Due to for sela coi that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) ed by the a g 🔲 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗶 No 흔 Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check unly ona) Gertifying Nurse Practiceen To the best of my knowledge, death uncorn id at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month. Day. Year)

JRW

Registrar

31. Date filed (Month, Day, Year)

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32. Registra s Signature

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29/2010

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pounch Now MD - 106 (Truing) Street
Washing time

2010

Please Type or Print in Black Indelible Ink, Fasure All Conjes Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Edward Blackburn, Sr. October 0 2010 Medical unk 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 270 Buckler Road Huntingtown Calvert Social Security Number If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Funeral . Age (In vrs. last birthday 8. Date of Birth 1 x M 2 □ F Davs Hours Min 02/07/1916 Director 213–22–1152 94 Maryland Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Calvert Huntingtown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 270 Buckler Road 20639 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural" 3XX Widowed 4 ☐ Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mential Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Meone. Elementary/Seconday (0-12) College (1-4 or 5+) Waste Management US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be William Charles Blackburn Marion Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Diane Hayes / Daughter P.O. Box 7 Prince Frederick, Maryland 20678 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Methodist Cem. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home. PA. Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 No g 🗌 Unknown been signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🗍 Probably 4 🖵 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy After this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Natural injury 2 🗌 No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title License number 29d. Date signed (Month, Day, Year) 006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARW) 10 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Marjorie Joan Baum 1:01 Рм 20°10 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Hospital Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 7 F Months Days Hours (Month, Day, Year 204-09-4425 Director 92 Pennsylvania Oct Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral with 1 23a 16923 Horn Point Drive 20878 United States items : hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1 Marital Status 14. Race - American Indian. Armed Force Black, White, etc. ö þ 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Management Services Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Amos Hinkle Martha Haen MARJORIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Cynthia G. Baum / Daughter 16923 Horn Point Drive, Gaithersburg, MD 20878 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery
Association 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State November 4 Weatherly, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 10 East Gaithersburg, MD 208 Deer Park Drive, Signature of Funeral Service Licenses any 1 RAGIA STUBE M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner acute Sequentially list conditions Examine cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No should be detached for Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 s has After this certificate 25. Was case referred to medica director. 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending s after death. Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital 24 hours Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) DD 066656 24040 October 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Medical Center Drive, Rockville, Pakeye, MD 9901 31. Date filed (Month, Day, Registrar

31,2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:30 A M 30, 2010 October Branagan Edward Francis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Aspen Woods Senior Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Min 1 X M 2 □ F May 10, New York Director 095-07-7027 93 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🔀 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 11908 Rocking Horse Road 20852 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1942−
If Yes, Give
Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Electrical Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be D. Branagan Anna Murtha ဥ Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20800 Layton Ridge Drive, Gaithersburg, MD. 20882 Edward F. Branagan, Jr./Son Important: If Item 2: any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crem. 11/3/2010 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Prostate Cancer Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 X No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Box 68760, P.O. I Hospital or Attending Physician: The law requires that the Records, certificate has breector, page 2 s Division of Vital funeral death. ours after death neral Director: / filled in by the f 24 hours To the I within 2 10+1

Pages 1 and 2 should be filed within 72 hours after

'natural",

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Health and Mental em 27 is marked o

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Baltimore, Maryland 21215-0036

Weihan Wang, M.D., 15245 Shady Grove Raod, # 130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) MOV 03 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Medical

State

Registrar

29b. Signature and title of certifier

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0067092

29d. Date signed (Month, Day, Year)

11/01/10

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		•	1 - For State Registrar	Oldio of Maryland	Cer	tificate of L	Death	,	Reg. N	0.	
	Dhysisis	m/	1. Decedent's Name (First, Middle, Last					2. Date of De	ath		3. Time of Death
	Physicia Medic	al		tler					_	2010 Year	1:50p M
	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or Location of Death Silver Spring 4c. County of Death Prince George's					rge's
Ī	Funeral		Renaissance Gardens 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birthp	place (State or Foreign
	Director		187-16-5239 1 1 Usual Residence of Decedent	M 2 □ F 9 0	Yrs.	monaro Dayo	110010	Sept. Is	3, 19	20	"'P A
	and show	to	10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Montg	omery	Si	lver Sp	ring				1 Yes 2 K No
	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho it th. Medical Examiner must be notified at	Funeral D	10e. Street and Number 3124 Gracefie	ld Road, Apt	. 40	10f. Zip Code	20904		10g. C	itizen of What Cour A	ntry?
	death r items ner m		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		14. Race - Americ Black, White,	
2-003p	s after ral", or Exami	ed by	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	ty xYes 2 □ No If Yes, Give 1942–70 Year or Dates.) 1	☐ Yes 2 🗷 No	Specify:			Specify: Whi	te
2-C	2 hour "natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	lent's Usual Occup	during most of wo	rking	16b.	Kind of Business In	dustry
1212	ithin 7, ene. r than	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	ONOT use retired) litary (₂	rmed_Fo	rces
ם א	iled w I Hygi other vent, t	æ	17. Father's Name (First, Middle, Last)		rii.	LICALY	18. Mother's Na	me (First, Middle,	, Maider	Surname)	rces
yiand	ld be f Menta Iarked atic ev	₽	Maurice Butl	er			Effie	Reich	cre	ek	
Mar	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2 be notified at other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty Kathryn E. Bu							or Town, State, Zip (Spring, MD 2	
aitimore,	Page 1 an Nent of He Int: If iten		20a. Method of Disposition 1 ☐ Burial 2 ③ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	emetery, cren	sition (Name of natory or other place n Cremator	y Nov	Date 4 , 010		Location - City or To	
Balt	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licens		22 F	Name and Addre	ss of Facility Collins Fu	neral Home		ng, MD 2090	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused the death						, , , , , , , , ,	Approximate Interval Between
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		ner	Sequentially list conditions if any, leading to immediate	b. Pulmonary Due to (or as a consequence)	Hyper ence of):	tension			_	-	
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. COPD		<u> </u>					
	icate be executed g physician and is the burial-transit	alE	resulting in death) Last	Due to (or as a consequent	ence of):						
2/00	ificate bing physias the k	Medical		d							76
BOX DS	4 0 , 6	Physician/N	in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	су			23d. Date of deliv Month	ery Day Year
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ς, Ο.	To the Hospital or Attending Physician; The law requires that the death cert within 24 hours after death suffered as the tribs certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use	ρ	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.			use contribute to the	he cause of death? bably 4 🛣 Unknown
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ī	cian;	Be	25. Was case referred to medical examiner?	Hospital:		26. P	lace of Death (Che				
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DIVISION	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (City or Tox		nd Number or Rura e)	l Route Number,
2	ospital hours ıneral d filled	Medical	29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	edge, death	occured at the time	e, date and place,	and due to the ca	ause(s) a	and manner as state	ed.
	the Ho hin 24 the Fu	Mec	only one) 3 Certifying Nurs	ner: On the basis of examination se Practioner: To the best of my	knowledge,	death occurred at th	e time, date and pl	at the time, date lace, and due to the	ne cause	(s) and manner as st	ated.
	a h		29b. Signature and title of certifier	1	, .	29c. Licens	21126 =	23	29a. D	ate signed (Month,	∪ay, rear)
,	10+1		30. Name and address of person who c	completed cause of death (Item	23a) (Type) F	Print)	1106-	ا در		10110	
				arding, CRNP		Gracefiel	ld Road, Si	llver Spri	ng, l	MD 20904	
	Sta Registra		31. Date filed (Month, Day, Year) NOV 03 20	32. registrar's Signatu	1. 4	NOW.					

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			for State Registrar	State of M	aryland /			of H	lealth			gien	- 2 1	10 3646
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	Exami ,	ner	4a. Facility Name (if not institution, g				4b. City, To					—,	c. County of	Death
E	Funeral Director				e (In yrs. last bi	rthday) Yrs.	If Under 1	Year Days	apoli If Under Hours	24 Hrs. 8 Min.	B. Date of Bir (Month, Da	th ay, Year)	9	Arundel Birthplace (State or Foreign Country) Vashington, D
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov							1,25	14 V	10d. Inside City Limits
	vith the Ma 23a or 28 st be noti	Funeral Director	Maryland Anne 2 10e. Street and Number 702 Harness Cree	Arundel		Anna	10f. Zip C	Code					Ditizen of Wha	*
9036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Me.#cal Examiner must be notified at.	ed by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E	ver in U.S.				panic Orio , Mexican		y Yes or No- can, etc.)	U	14. Race - A	States American Indian, White, etc. White
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	2 shouth and the shou		19a. Informant's Name/Relationship Mary H. Bull/wif						d Number	r or Rural Re	oute Number	; City o	r Town, State,	Zip Code) MD 21403
Baltimore,	2 1 e a		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	cemete Final	ry, crema Jour	ition (Name atory or othe ney Cr	of er place) C ema	tory	11/6	∘ /2010	20c. L	ocation - City	or Town, State
Bal	permit. F Departm Importa any inju		21. Signifiate of Funeral Service Lice	homos	M0095	GÖ Be	Name and A ing Ho verly	Address DME L.	of Facility Crema Hecki	ation rotte	Servi	ce l	P.O. Barksvi	ox 784 lle, MD 21029
F	Physician/ Medical		23a. Part. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused to one cause on each line. a	Sep./	not enter	the mode o	f dying,	such as c	cardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month 2010 Philip Eugene Breeding /Medical November 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Vorchester Cambridge Hospita 5. Social Security Number If Under 1 Year | If Under 24-Hrs. 9. Birthplace (State or Foreign Country)
Maryland Funeral 8. Date of Birth (Month, Day, Days Hours 1 XM 2 ☐ F 216-16-7096 Director 85 December 22,1924 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notities at 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7185 Breeding Road 21632 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Philip Eugene Breec Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: to 1946 1 ☐ Yes 2 🛣 No <u>ک</u> 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Button Cutter Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Fred T. Breeding Hazel Irene Drummond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Virginia Lee Breeding/spouse</u> 7185 Breeding Road, Federalsburg, Maryland 21632 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Concord Cemetery Nov.10,2010 Federalsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. ande 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, ... complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition Lwecks /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 1 ☐Yes 2 No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1 □ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death After 1 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

ix

DHMH 17 Rev 1/2001

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

William Bair

NOV 09

300 Byrn Street, Cambridge, Maryland

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. Ligense number 043238

29d. Date signed (Month, Day, Year) November 7, 2010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiana

			For State Registrar	State of M	aryland		tificate of L	Death	nental Hy	Reg. No. ()	0	36465
	Physicia	ın/	1. Decedent's Name (First, Middle, Irene W. Bray	Last)					2. Date of De Month	ber 4 201	Year	3. Time of Death
	Medic Examir		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or	Location of Death	Novem	4c. County of		3:00a ^M
			Calvert Manor				Rising			Cecil		
	Funeral Director		5. Social Security Number 021-07-2147	6. Sex 7. Age 1 M 2 XF	e (In yrs. last i 97		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 10		9. Birthp Coun	
			Usual Residence of Decedent		97	110.		<u> </u>	Aug 10	, 1913		NJ
	yland -f sho ed at	ctor	10a. State 10b. County		10c. City, To	own or Loc	ation				1	0d. Inside City Limits
	r 28a notifi	Director	MD Cecil 10e. Street and Number		Risin	g Sun	10f. Zip Code			40. 00		1 Yes 2X No
	with the	Funeral	1881 Telegraph	Rd.			21911			10g. Citizen of W	nat Cour	nry?
	death items ier mi		11. Marital Status	12. Was Decedent E	ver in U.S.	13. W		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race		an Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ary injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 X Yes 2 I If Yes, Give Year or Dates.	No		Yes 2 X No		Tilodity otoly	Specify:	k, White, 6	ite
15-(72 hou n "natu ledica	Completed	15. Deceden (Specify only highes	t's Education st grade completed)	1	(Give k	ent's Usual Occup ind of work done o	ation during most of worki	ng	16b. Kind of Bus	siness Inc	dustry
72	within giene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5	i+)		NOT use retired) rter			News N	Modit:	9
pu	filed val Hyg	Be C	17. Father's Name (First, Middle, La	ast)				18. Mother's Name	e (First, Middle,	Maiden Surname)		
yla	should be file n and Mental I 7 is marked c raumatic eve	잍	Emil Weise					Viola Re	gina A	be1e		
Maryland	2 shou Ith and 27 is n r traum		19a. Informant's Name/Relationsh Luise A. Willia					and Number or Rura Happy Can			ate, Zip C	Code)
	1 and if Heal item 2		20a. Method of Disposition		20b. Place	e of Dispos	ition (Name of	1	Date	20c. Location - 6	City or To	own, State
Baltimore,	permit. Page Department of Important: If any injury or once.		1 ☐XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)			atory or other plac hristian	e II/8 a Cemeter	3/2010 'y	Newark,	, DE	
Bal	Depar Impos any ir		21. Signary Funeral Service Li	Sensee and	3	R 12	Name and Address T. Foard 2 W. Mai	s of Facility and Jone n St. Nev	satk, Inc	È 19711		
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or	complications that caused nly one cause on each line	the death. D	o not enter	the mode of dying	g, such as cardiac c	r respiratory ar	rest,		Approximate Interval Between
1	Priysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a De	ly	ds	atro	n-			1	Onset and Death
	Examiner		, and any	o (or as a	a consequenc	ce of):	2	6				
-	_ +	iner	Sequentially list conditions, cause. Enter Underlying	b. Sum to (or as a	nonsequent	acty d	ine				\dashv	7/00/7/20
	and transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Act	a consequence	ne of:	170	i/me				15 WKS
0	cate be executed physician and s the burial-transit	calE	resulting in death, cast	7 500 10 (0) 10 0	a concoquenc	30 01).	/					
3760	ificate ig physas the	Medical	IS ESSAULE:	d								
<u>ت</u> ×	th cert trendir or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 - Fetal de	eath 3 🔲	Ectopic pregnanc	у		23d. Date		*
P.O. Box 68	he dear y the ar	Physician/N	1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of deat	h 5∐	Other (specify)			Mon	in	Day Year
P.0	s that t gned b	by	Part II. Other significant condition	ns contributing to death be	ut not resultin	ng in the un	derlying cause giv	en in Part I.		obacco use contrib		
rds	equire leen si hould I	eted							1 -			oably 4 🗆 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Completed								osy pr ormed? de	ior to coreath?	osy findings available impletion of cause of
<u>e</u>	ian: T	Be C	25. Was case referred to medical examiner?	12			26. Pla	ace of Death (Check	only one)	2 L No 1	☐ Yes	2 LJ N0
⋛	Physic this ce al dire	၉	1 ☐ Yes 2 ☑ No 27. Manner of Death		ent 2 ER/			4 LU Nursing Ho		dence 6 Other)
0 0	rding l tth. : After e funer	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investiga		(Year)	o. Time of injury	28c. Injury work' M 1 🗆		28d. Describe h	ow injury occurred	1	
Visio	or Atter fter des irector n by the	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 280 Place of Inju		farm, stree			28f. Location (S	Street and Number	or Rural	Route Number,
	spital cours at eral D		29a, Certifier 1 Certifying	Physician: To the best of	my knowleda	e death or	ocured at the time	date and place, and			as state	<u> </u>
	he Hos in 24 h ar Fun pleted	Medical	(Check 2 \(\sumeq\) Medical Ex	aminer: On the basis of ex Nurse Practioner: To the basis	camination and	d/or investig	gation, in my opinio	n, death occurred at	the time, date a	ind place, and due t	to the cau	use(s) and manner stated.
_	Vom Com		29b. Signature and title of certifier	e o v l	1	1.1	29c. License	number	7	29d. Date signed	(Month, E	Day, Year)
	Aldula		20 Named address of asset	ho completed assess	ath (la == 00	101)	1807	トクロ	/	11/04/	20	7/0
	4.414		JAYANTILA	ho completed cause of de	ELI	mi) (123 Sim	gerly ;	Aveji	FLKTON	K, M	1721921
	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 8 2010	32. Registra	r's Signature	New		,	,			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010^{ear} **Physician** November 10:30a Kenneth W. Baldwin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. | S. Date of Birth (Month, Day Year) | Sept. 23,1949 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F PA 61 Yrs. **Director** 200-36-5074 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show the Medical Exprimer must be notified at 1X Yes 2 □ No Director Ceci1 E1kton MD 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ USA 21921 103B Courtney Dr. 'natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status hours after 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify: 2 White 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemica1 Engineer Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Jensen ပ H. Wayne Baldwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra 259 E. Main St. Elkton, MD 21921 Edward McKeown/ Friend 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/23/2010 4 Donation 5 Dother (Specify) Hope Cemetery Aston, PA permit. 22. Name and Address of Facility R.T. Foard Funeral Home 259 E. Main St. ELkton, 21. Signature of Funeral Service Licen Home, P.A. kton, MD 21921 Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dyir, Part 1. Enter the disease, or complication shock, or hear failure. List only one cause on each from mediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably After this certificate has been so funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes spital or Attending Physician; Thours after death.
Inceral Director; After this certificat if filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Hospital of 24 hours at De Funeral D the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely one) and manner stated To the within 2 29b. Signature and tyle of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

Day.

NOV 08

e and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36468 State amend 16ab, 17 per f.h. g909 Cartifit and of Reath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month July 2010 Year PM AVA ELIZABETH CALDERON-POITER 4:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral July 21, Year 2010 1 □ M 2 🔀 F Days Min. Hours Maryland **Director** Usual Residence of Decedent 28a-f shov aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified 1X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Long Acre Court Funeral 21702 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2 Married δ If Yes, Give 1 X Yes 2 ☐ No Specify: white Specify 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alban Castaneda ပ is marked Amy Michelle Poiter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health al Important: If item 27 is any injury or other trau Amy Michelle Ramos - mother 121 Long Acre Court, Frederick, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 7-26-2010 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee Signa 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Extreme Physician/ disease or condition resulting in death) 20 mai Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant 9 Unknown signed by the a 1 ☐ Yes 2 ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 1 N 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 📈 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/29/2010 MOD 61173 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Thomas

Johnson DR. #H

Frederick, mo 21701

Sweener

Year)

9 2010

Joanne

31. Date filed (Month, Day, Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11-01-2010 Adolfo Antonio Castro 1:17 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. E1 CSalvador 05<u>~07~1</u>974 Director 36 None Usual Residence of Decedent 28a-f show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector 1

Yes 2 □ No Prince George Hyattsville ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 El Salvador Park Drive 7200 W. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 🖔 Yes 2 □ No Specify: salvadoran If Yes, Give Year or Dates. Specify:Hispanic "natural" 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 9th College (1-4 or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk
Department of Health and Mental I
Important: If item 27 is marked c
any injury or other traumatic eve Maria Erminia Castro Abran Deonicio Climaco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 W. Park Drive Hyattsville, MD 20783 Gabriel Acevedo (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery El Salvador 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licen 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final GROCHADITIS Physician/ YROSTHETIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner STAPH LO LOCKUS Securitially list conditions if any, leading to immediate cause. Enter Underlying Examine physician and s the burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): resulting in death) Last LOSTRIDIOM Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No page 2 this certificate 2 No ☐ Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of nours after death.

neral Director: After the filled in by the funeral 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fi The discal Examiner: On the basis of examination and/or investigation, in my opinion, death become at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 12004495

State

Registrar

30. Name and address of person who completed cau

Randall P. Wagner

MOA

31. Date filed (Month, Day,

7600 Carroll Avenue Takoma Park, Maryland 20912

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vovember 4 2010 Genevieve Crawford 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hospital 1albor astor 8. Date of Birth (Month, Day, Year)
Dec. 27, 1920 7. Age (In yrs. last birthday Year If Under 24 Hrs place (State or Foreign 5. Social Security Number Months Davs Hours 1 □ M 2 □ XF Mary land 216-12-4151 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Caroline Denton Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21629 503 South Second Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Family Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Olga Trau Frank Stetka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 502 South Second Street, Denton, Maryland 21629 Susan Miller/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.5, 2010 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. andif 21629 12 South Second Street, Denton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 3 No 70-1∏ Yes ta

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Be Completed by Funeral

Funeral

Director

D partment of Health and Mental Hygiene.

In portant: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at or e.

death with the Maryland

Pages 1 and 2 should be

Examiner

Physician/Medical

Completed

Be

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Certification:

Medical

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the Funeral Director: Af

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Hospital or Attending

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

28d. Describe how injury occurred

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

1 Tes 2 No 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 S. Washington Street, Easton, MD 21601

Dennis DeShields 31. Date filed (Month, Day, Year) NOV 0 8 2010

32/Registrar's Signature

and manner stated.

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2010 october Kathryn Bee Cox 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Donchester General Hospita ambridge Douchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, 1 □ M 2 🕱 F Days Hours Min. 216-40-4020 69 05/05/41 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Caroline 1 ☐ Yes 2√2 No MD Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Liberty Road 21632 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2▼ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 2+18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Garcia H. Bee Dorothy L. Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly C. Dayton/Daughter P.O.Box 28, Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State East New Mkt., East New Mkt. Cem. 11/03/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licenses Michael Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nd Immediate Cause (Final Stole disease or condition resulting in death) Due to (or as a con equence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 M 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thipatient 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed and burial-tran P.O. Box 68760, the attending physician as the use Po detached signed by t Division of Vital Records, peen has within 24 hours after death.

To the Funeral Director. After this certificate I committeely filled in by the funeral director, pag. the Hospital or Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

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Examine

Physician/Medical

Completed

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Certification:

Medical

Funeral

Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Mydical Experiment ust by refilled at once.

Physician

Examiner

/Medical

Rathmyn Cox Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 11-1-10

MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN 503 BYRN THANWY CAMBRIDGE

State Registrar

31. Date filed (Month, Day, Year)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		S	state o	f Marylaı		artment of H		and N	lental Hy	giene	e		
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)									36472							
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-310	Exami		Montgomers						Olney	Location	or Death			c. County o		
	Funeral		5. Social Security No		6. Sex	. NO =	7. Age (In yrs.	last birthday)	If Under 1 Year	r If Under 24 Hrs. 8. Date o			Birth 9. Birthplace			lace (State or Foreign
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	and show at	5	10a. State	10b. County			10c. Ci	ty, Town or Loc	ation						1	0d. Inside City Limits
	Maryla 18a-f	Director	MD	Mor	tgome:	ry		Silver	Spring						- [1 Yes 2X No
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and	be file ental H ked o c eve	일	17. Father's Name (F Harry F.		ast)							(First, Middle, i Smith	Maiden	Surname)		
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Σ	d 2 sk alth a n 27 is er trai		Robert A. D			,			Fox Meadow						ite, Zip Ci	ode)
ore	of He of He if item r oth		20a. Method of Dispe		۰		20b. F	Place of Dispos	ition (Name of	- 1		ate		ocation - C	ity or Tov	vn, State
Ĕ	Page ment tant:		4 Donation	5 Other (S)	oecify)	oval from S	state G	ate of H	atory or other place eaven Cemet	ery	Nov. 2010	5,	Sil	ver Sp	rina.	MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fun	eral Service Li	censee	, ,	0	22. Fr	Name and Address	s of Facili	ty Fune:	cal Home			<u> </u>	
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	Io the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for the funeral director.	ᄝᅵ	(Ollock Z	INICUICAI EX	illiller. Of	The Dasis	or examination	and/or investig	cured at the time, dation, in my opinion,	death oc	curred at th	ne time, date and	d place.	and due to	the causi	e(s) and manner stated.
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OCTOBER	h with ns 23a must l	11413 Applegrath Way 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes specify Cultur Meyican Plents Rican etc.) 14. Race - A														
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G RAY DRAGER Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y la	19a. Informant's Na	me/Relationship (7	Type, Print)		19b. Ma	iling Addres	ss (Street a	and Numb	oer or Rura	Route Numb	er, City	or Town, Sta	te, Zip C	Code)
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Division of Vital Records, P.O. Box 68760	To the hospital or Attending Prysician; The law requires that the deam certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom	e of pregna	ancy							23d. Date	of delive	ery
Box	neath ie atte	sicia	in the past 12 n		1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	at time of		Other (СУ				Mont	h	Day Year
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ı of	Jing P	ate	27. Manner of Death 1 Natural	5 Pending	28a. Date of in (Month, D	jury <i>lay, Year)</i>	28b. Time injury		28c. Injun work	yat <br Yes 2 □	- 1	28d. Describe	how inju	ury occurred		
Sioi	Attend r death ctor: .	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Ir	njury - At h	ome, farm,			res ZL		28f. Location	(Street a	and Number	or Rural	Route Number,
D <u>V</u>	s afte		4 🖾 Homicide	determined	building, e	etc. (Specif	(y)				- 1	City or To	wn, Sta	te)		
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	= ≥ ₽ 8 A)		BWD					027			200.L	10/27	í	
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9			State Registrar			Cer	tificate of l	Death			Reg. No			
530	Physicia Medic		1. Decedent's Name (First, Middle Jeannette	,	eman					2. Date of De Month Octobe:	Da	y 2010	3. Time 0	
-	Examir		4a. Facility Name (if not institution,			- /	4b. City, Town, o	h				. County of Dea	uth	
6	F		Shady Grove Advertist to Spirtal Rockville M 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth							10 Ntgo	rthplace (State	or Foreign		
0	Funeral Director		218-50-5714	1 □ M 2 1 F	57	Yrs.	Months Days	Hours		June 3	, 1 ⁹ 53	of of	Collins F	gict
140	od sow	L	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	eation						10d. Inside 0	City Limite
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an, Seannette. Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 M If Yes, Give Year or Dates.	?	li li	Vas Decedent of H Yes, specify Cuba	an, Mexica	ın, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify: W		
eannet	72 hou n "natu fedica	nplet	(Specify only highe	t's Education st grade completed)		16a. Deced	ent's Usual Occup ind of work done of NOT use retired)	ation during mos	st of workir	ng	16b. Ki	ind of Business	Industry	
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 4	r 5+)		omemaker				C	Own Hom	e	
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	12 sho Ilth and 27 is i		John C. Dieman	1 . 27			g Address <i>(Street .</i> Brandon							
Sieman more, Mai	of Health of Health fitem 27		20a. Method of Disposition			ace of Dispo	sition (Name of natory or other place	1	D	ate	20c. Lo	ocation - City o	r Town, State	
$\sum_{i}e_{m}$ Baltimore,	. Page iment c tant: If jury or		1 🄀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Par	klawp	Memoria]	,6)	Nove 20	mber 3 10	Roc	kville,	MD	
Ball	permit. Pag Department Important: any injury c	6 60	21. Signature of Funeral Service L	Day	MO11	.16 De	Name and Addre	ss of Facili ral H Gai	Home, Lthers	10 Eas	st De MD 2	er Parl 20877	k Drive	,
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cause nly one cause on each li	ed the death. ne.								Approxima Interval Be	ate etween
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Respi	rato	CY	Failu	e					Onset and	
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	7.0 ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dus to (or as	α συπσόψικ	nies une		1			$\widehat{}$		* .	_
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09	cate be executed physician and the burial-transit	dical	, , , , , , , , , , , , , , , , , , , ,	Bra	in:	Ini	rry a	x a	rge	7			00	1F
	tificate ng ph) as the		IF FEMALE:	1		- 0	7		1			2-m 1	b 10"	· L.
Box 687	eath cer attendii d for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	4 🔲 Pregnant	2 Fetal at time of de	death 3 [Ectopic pregnand Other (specify)	;y \	7/	Ne	N	≥3d. Date of de Montil		Year
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by	Part II. Other Significant condition	is contributing to death	put not resu		idenying cedargin	\		1 🗆	Yes 2[se contribilite to	Probably 4	Unknown
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Divis	al or At s after c al Direct ed in by		4 Homicide determi	28e. Place of in	ijury - At hom tc. (Spec <i>ify</i>)	e, farm, stre	et, factory, office		2	28f. Location (S City or Tow レか	m, State)	d Number or Ru	iral Route Num	ber,
_	ne Hospi n 24 hour ne Funera	Medical	(Check 2 Medical Ex	Physician: To the best on the basis of Nurse Practioner: To the	examination a	and/or investi	gation, in my opinio	n, death o	ccurred at 1	the time, date a	and place,	and due to the	cause(s) and ma	anner stated.
			29b. Signature and title of certification		m	17	29c. License					e signed (Mont		
	20		· Ma	X	11/1	. 1/.	D 6 9				Octo	ber 2	9,20	10
			30. Name and address of person w		death (Item 2	(Type, Pr	center	er s	ייינע (e Roo	· Vari	llo M	10.20	850
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty Drennan 2010 October 2:56 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 □ M 2 👿 F (Month, Day, Year 05/04/1927 Director .23–16–6229 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No NY Middletown Orange 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 63 Mountain Avenue 10940 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Dental Assistant Dental Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stanley C. Clinton Lena S. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lentino/daughter 1732 Peppermint Lane, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Denial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wallkill Cemetery 11/6/2010 Middletown 22. Name and Address of Facility Pritts Funeral Home Signature of Funeral Service Licensee A-412 Washington Rd., Westminster, MD 21157 23a. Pani 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset, and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hybranian and Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 Month Day Pregnant at time of death Yes 2 should be detached 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Probably 4 🗌 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons perform funeral director, page 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practimer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MJL

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State Registrar ESTHIUSTE

ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36476 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20T0 Anna E. Dolan 11:58aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ceci1 Union Hospital E1kton 8. Date of Birth
(Month, Day, Year)
Dec. 3, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🛣 F Director 165-18-8760 90 Dec. Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Philadelphia PA Philadelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19116 USA 730 Byberry Road #514 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Types 2 No
If Yes, Give
Year or Dates. 1944-46 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 ₩ Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kotroba Anna Walla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryanne Dolan / Daughter 104 Milestone Road ELkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Magnolia Cemetery 11/3/2010 4 Donation 5 Other (Specify) Philadelphia, PA 21. Signature of Fune al Service Licensee 22. Name and Address of Facility John Givnish Funeral Home 10975 Academy Rd. Philadelphia, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rospitatory Physiciani disease or conditio Medical resulting in death) consequence Examiner 6hrs meumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami sician and burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Disease with recent or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) မ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗒 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, 266176 nerma 101 110. 29

State Registrar

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VINAY

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Union Hospital

106 Bew St, Elkton, MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SHARMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 10/29/2010 ar Physician/ 13:55 рм Clarisse W. Dixon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's **Examiner** Southern Maryland Hospital Center Clinton Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 屎 Hours Min 578-46-4288 67722/1932 Director 78 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Upper Marlboro MD Prince George's 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20772 15701 Croom Airport Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Yes 2 No 1 Never Married 2 XXMarried δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Margaret Rebecca Butts Leonard Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15701 Croom Airport Rd., Upper Marlboro, MD 20772 William R. Dixon/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery 11/05/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Brentwood, MD 4 Donation 5 Other (Specify) Signature Fineral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M Mounts Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be #3 (2) #4 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pendina Accident
Suicide thin 24 hours after death.

the Funeral Director: Af
mpleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and date to this cause(s) and manner as added. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

15

31. Date filed (Month, Day, Year

TRM

Wendell Pierson 7503 Surratts Road, Clinton, MD 20735

32. Registar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 3. 20ÎÖ 9:30 PM Laura Belle Dvott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Talbot Hospice House Talbot Easton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. June 17, 1922 Marvland 220-01-1409 88 Director Usual Residence of Decedent shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 28a-f 1 🗆 Yes 2 ី No Maryland Caroline Denton 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 8370 Tuckahoe Road 21629 U.S.A hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Family 5 4 1 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and injury or other traumati ည Herman H. Hill Sarah Elizabeth Hurlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8370 Tuckahoe Road, Denton, Maryland P. Steven Redden/Grandson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Nov.8, 2010 Hillsboro, Maryland Signature of Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A. ando Street. Denton. Maryland South Second Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aceiden disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to in recipitate cause. Enter Underlying Examine Due to lor as a considuence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 Se IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Specify) nours after death.

neral Director: After this dilled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 2 ☐ Accider 3 ☐ Suicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 1. ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0047534 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zaki Denton MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MOV 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 134 heodore aumar Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medica Maryland Baltimore City Baltimore, Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 Ø M 2 □ F Months Days Hours Min. 1072971951 216-60-5583 Washington, D.C. Director Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Caroline Denton 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 Funeral 1206 Market Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 721 (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Coins Elementa 2/Seffon Say (0-22 rad College (1-4 or 5+) Businessman \$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental F ၉ Samue1 Dayman Williams Ruth other traumatic ge 1 and 2 should be nt of Health and Mer : If item 27 is marke 19b Mailing Address (Street and Number or Rural Route Number City or Jown, State, Zip Code) 1206 Market St., Denton, MD 21629 19a. Informant's Name/Relationship *(Type, Print)* Teresa J. Dayman / wi Department of Hear Important: If its any in: Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory 20c. Location - City or Town, State Date 10/31/2010 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A., 12 S. 2nd St., Denton, MD 21629 23a. Part 1 Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ moxemia disease or condition Medical resulting in death) **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed and-trans resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 -25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural injury work 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wong 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

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egistrar's Signatur

MD

225 Gireene Street, Baltimere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36480 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Day Physician/ Month 5:42 Oct Billy W. Eddins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital

5. Social Security Number | 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Days Months 3 28 7 1 9 2 9 Virginia 81 25-32-9564 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20010 7058 Eastern Avenue,

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14 Race - American Indian

12. Was Decedent Ever in U.S.

Funeral Director or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, in tiems 23a or 28a-f sho Important. If item 27 is marked other than "natural", or items 29a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. once. Baltimore, Maryland 21215-0036 Priysician

11. Marital Status

Medical **Examiner** Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

d by Fi	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.		Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, Whit	e, etc.	
Be Completed by	15. Decedent's E (Specify only highest gra- Elementary/Seconday (0-12) 12th.	ducation ade completed) College (1-4 or 5+)	(Give kir	NOT use retired)	ation Juring most of wor	-		Kind of Business Govern		
To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Conway									
	· ac	on, DC								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Respiratory Failure Due to (or as a consequence of):									
Medical Certificate: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any bading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last									
ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3 🔲	Ectopic pregnand Other (specify)	у			23d. Date of de Month	delivery Day Year	
ted by Pl	Part II. Other significant conditions co		Iting in the und	derlying cause giv	en in Part I.				o the cause of death? Probably 4 💆 Unknown	
Comple	Respiratory Distress Due to Resp. Failure 24a. Was an autopsy performed? 1 Yes 2X No									
ge (25. Was case referred to medical examiner?			26. PI	ace of Death (Chec	ck only one)				
0	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 K	R/Outpatient	3 DOA Oth	er: 4 Nursing H	lome 5 Res	sidence	6 Other (Spec	cify)	
ificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not by	(Month, Day, Year)	28b. Time of injury		rat ? Yes 2 □ No	28d. Describe		·		
al Cert	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		•		City or To	wn, Stat	re)	ıral Route Number,	
Medic	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my	and/or investig	ation, in my opinio ath occurred at th	n, death occurred a time, date and pla	at the time, date	and place the cause	ce, and due to the e(s) and manner as	cause(s) and manner stated. s stated.	
	29b. Signature and title of certifier	2 m		29c. License				ate signed (Mont / $28/201$		
	30 Name and address of person who o	completed cause of death /Item	23a) (Type Pri	D0063	434		10/	20/201		

15245 Shady_Grove Rd--Suite 130; Rociville, MD 20850

State Registrar Patricia S. Gomez,

31. Date filed (*Month*, *Day*, *Year*) **NOV 03 2010**

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV. Day 0 1 0 Year Hester Ryan Essex 1, 6:15 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 525 Whittingham Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 6. Sex **Funeral** 577-09-3778 100 Yrs Days Hours (Month, Day, Year) 1 M 2 5 F Director June D Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d, Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 K No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral 525 Whittingham Drive 20904 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ♥ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Utilities Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Mertens Ryan Katie Travers Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita M. Bane/Niece 10232 Confederate Ln., Fairfax, VA 22030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗀 Other (Specify) Noy.8 Parklawn Memorial Rockville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ACOTE MYOCADIAL INFARCTION Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 10 signed by the atte 5 Other (specify) Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Presidence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar BARRY

31 Date filed (Month, Day,

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NOV 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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FARRAGOT AUG KEUSINGTON, MD ZOSIS

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		State of Maryland /	Department of Health and I		0 36482					
_		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2. Date of Death						
Physici Medi	cal	Mari Angela Ellis		October 27, 201						
Exami	ner	4a. Facility Name (if not institution, give street and number) Shady Grove Hospital	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery					
Funeral		5. Social Security Number 6 Sex 7 Age (In yrs last bit	rthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	B. Birthplace (State or Foreign					
Director		212-95-5185 1 ☐ M 2 🛱 F 47 Usual Residence of Decedent	Yrs. Months Days Hours Min.	July 23, 1963 M	laryland					
faryland Ba-f shor tified at	Funeral Director		vn or Location r Spring		10d. Inside City Limits 1 ☐ Yes 2 🌠 No					
a or 2 be no	Ö	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha						
th with ms 23 must	ner	3810 Greenly Street	20906	United S						
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes of No- p Rican, etc.) 14. Race - Black, Specify:	American Indian, White, etc. White					
Z1Z13-0U36 within 72 hours after giene. fer than "natural", o	Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Spatcher	16b. Kind of Busin Heating of Condition	and Air					
C C Hygir other ent, ti	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)	nichy					
lantal lental rked tic ev	욘	David Paul Ellis		e Sciamanna						
INALYIAIIO 2 should be filed th and Mental Hy 27 is marked oth traumatic event			9b. Mailing Address (Street and Number or Ru							
and 2 Health em 27 ther t			0437 Ambassador Terro	Date 20c. Location - Ci						
Page 1 Trent of ant: If it		1 Burial 2 X Cremation 3 Removal from State cemet	ery, crematory or other place) incoln Crematory 11/		d. Maryland					
emit. Page 1 and Department of Hee Important: If item any injury or othe once.		21. Signature of Funeral Service Licensee MOILO 2	22. Name and Address of Facility Siv Center, Edmonston (1040 Rockville Pike	aple Tribute Func rossing Shopping	eral & Cremati Center					
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as pronsequence of):								
be executed be executed sician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or unjury that initiated events resulting in death) Last b. Due to (or as a consequence consequence) C. Due to (or as a consequence)								
Hospital or Attending Physician: The law requires that the death certificate be ex 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician attending physician death in by the funeral director, page 2 should be detached for use as the burial	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		23d. Date of Month						
ires that the des signed by the a	Š	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribu	ute to the cause of death?					
The law requires cate has been signage 2 should b	Completed			autopsy price performed? dea	re autopsy findings available or to completion of cause of th? Yes 2 □ No					
ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)						
al or Attending Physician: s after death. al Director: After this certific	cate: To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing H Time of injury at work? M 1 Yes 2 No	ome 5 Residence 6 Other (28d. Describe how injury occurred	Specify)					
Hospital or Attending Pl n 24 hours after death. The Funeral Director: After the filed filled in by the funeral	I Certificate:	2 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number of City or Town, State)	or Rural Route Number,					
To the Hospital or within 24 hours aft. To the Funeral Dir	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge only one) 1 Certifying Nurse Practioner: To the best of my knowledge	or investigation, in my opinion, death occurred	at the time, date and place, and due to	the cause(s) and manner stated					
within comp	2	29b. Signature and title of pertifier	29c. License number	29d. Date signed (A	Month, Day, Year)					
3		Cel H. Arbuely	MP D 26540	October.	27, 2010					
		30. Name and address of person who completed cause of death (Item 23a) Carl Schoen berger, MD 1622		uite 213, Gaither	bury, Morvial 200					
Sta		31. Date filed (Month, Day, Year)	hald		11 11 11 11 11					
Registi	ar	NOV 04 2010 Centra A. 2	4940							

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OCTOBER 27, 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06:10 P M Dale Warren Edwards, Sr. October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Prince George's Clinton Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 20, 1 9. Birthplace (State or Foreign Country)
Washington, DC Social Security Number '. Age (In yrs. last birthday) If Under 1 **Funeral** Days 1**火** M 2 □ F Months Hours **Director** 1965 220-96-7425 44 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits with the Maryland traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 XNo Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral or items 23a 2704 Ritchie Road 20747 United States should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force þ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Handvman Home Improvements Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eugene Warren Edwards Alice Edith Cuppett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Dale Warren Edwards, Jr./son 106 Chesapeake Mobile Court Hanover, MD 21076 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/4/2010 Woodbine, Maryland e of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Acute Atheroscierone Cardiovascula Onset and Death Immediate Cause (Final Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any leading on the cause. Enter Underlying Cause (Disease or linjury Examine Divi to for as a consequence of: burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the l 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BYPESS 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Arley Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an malliathe has autopsy performed? Yes 2 No this certificate HYPEVELOSIOS 1 🗌 Yes 2 🔲 No 25. Was case referred to medical examiner?

1 Yes No 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 R/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 \(\sime\) Yes Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number K MALM D50659 SULTREYS MANIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🛕 📢 👢 K MAHAJAN MD

State

Registrar

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31. Date filed (Month

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Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death o&th 27 Physician/ Da 0 1 0 Year 7:30P Walter James Evans Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Westminster 4c. County of Death **Examiner** Golden Living Center Carroll 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 XM 2 🗆 F Months 192-18-875\$ 87 Yrs. 1 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster MD Carroll 1 Yes 2 No 10f. Zip Code 21158 10e. Street and Number 10g. Citizen of What Country? Funeral 323 Royer Rd. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🔀 Yes 2 🗌 No Black, White, etc. þ 1 Never Married 2 Married Specify: white If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 XWidowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Railroad Maintenance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sands ൧ Harold Evans Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codel 323 Royer Rd., Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) Janice E. Knight-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🖾 Removal from State cemetery, crematory or other place Forest Lawn Gardens 11/3/10 McMurray, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Faleral Service Licenses 22. Name and Address of Facility Fletcher Funeral F 254 E. Main St., Westminster, MD Home 21157 homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 15 yrs Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami 25 yrs cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4XX Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

WJL ITIVA

State Registrar 3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

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29b. Signature and title of certifier

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31. Date filed (Month,

only one)

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

H0061206

Westminster, MD 21157 - TRade L. Ryberg

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2000

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Rosabelle Brown French November 6:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 12488 Catalina Drive Lusby If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** New Hampshire Days Min. 1 🗆 M 2 🖼 F Director 003-14-0365 85 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🖾 No Marvland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 12488 Catalina Drive 20657 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 M Married Yes 2 3 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chief of Occupational Therapy Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Floral Cattanach Hubert Leslie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .s je 1 and 2 s t of Health a If item 27 i Ian Maclaren French, Sr./Spouse P.O. Box 1346, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Important: If it any injury or o 1 Durial 2 Cremation 3 Removal from State 11/04/2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Box 600, Lusby, Maryland 20657 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner De Sequentially list conditions, Examine Due to (or as a sonsequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: yes, outcome of pregnancy asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ģ Month Day Pregnant at time of death 1 Yes 2 No ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🛮 Natural 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Z.Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allows investigation, army opening of the cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) haveri. Ruta D32651 November 4, 2010 5W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Jhaveri, MD 22335 Exploration Drive, Suite 1035, Lexington Park, MD 20653 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV - 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/AMEND#23bperMD, 11/5/10, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct. Physician/ ^{Day} 2010 31 3:33 P M Kenneth Preble Ferguson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Rethesda 8. Date of Birth Jan . 26, 1920 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 🕱 M 2 🗆 F Months Florida Director 90 266-18-6020 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 U.S.A. 8036 Lilly Stone Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc. by 1 Never Married 2 🙀 Married 1 X Yes If Yes, Give 2 No. 1937-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 1945 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med Department Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Officer of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Jesse Alexander Ferguson Ariadne Preble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8036 Lilly Stone Dr., Bethesda, MD 20817 Marian L. Ferguson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State Nov.1,2010 Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home . Signature of Funeral Servic M01315 Kur 97 DC 20007 222 Wisconsin Ave., NW., Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart fallure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): Examiner Seizure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: REMOVE ITEM 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death
Unknown 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy Yes B B

31/2010 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis by physicis has present filled in by the funeral director, page 2 should be detached for use as the burn placed filled in by the funeral director, page 2 should be detached for use as the burn. Records, FAIN Vita Division of Reason

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25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manur of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10/311

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd. Bethesda, MD 20814-1422 Babak Pirouz, MD

State Registrar

Certificate: To

Medical

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Theodore Herbert Green 28, 2010 2:06 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1908 Stone Road Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Aug 124, 1 X M 2 □ F Months Days Hours 87 213-40-0752 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at Funeral Director Westminster Carroll Maryland 1 🗆 Yes 2 🗶 No 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 21158 1908 Stone Road items 23a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Was Deceden. Armed Forces? ✓ Yes 2 No 14. Race - American Indian, Black, White, etc. 6 þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white Specify. "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. Agriculture 10 Dairy Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ္ Mary Etta Parrish Delbert E. Green permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code; 703 Cherrytown Road, Westminster, MD 21158 Ramona S. Rawlings, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/02/2010 Westminster, MD Pleasant Valley Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Sign ature of Funeral Service Licenses Myers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Inset and Death hoof, or heart failure. List only one cause on e Immediate Cause (Final Physician/ conver Y05 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Was a. autopsy performed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has al director, page 2 2 **N**o 1 Tes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗹 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death. neral Director: Aff I filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 24 hours a Funeral E Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi ☐ Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Praction of To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier WIL 15

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who

31. Date filed (Month, Day, Year)

125 AIRPORT DRIVE, STE. 34, WESTMINSTER, MD.

ath (Item 23a) (Type, Print)

completed cause of de

J. RUZBORSKY

m. b.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death OCTO DEL Physician /Medical Harr 11:02 a.M 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 4/26/1949 5. Social Security Number 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days 221-34-1225 61 DELAWARE **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a State 10h County 10c. City. Town or Location show notified at 1 ☐ Yes 2 X No Director 28a-f MIDDLETOWN DF. NEW CASTLE 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö r than "natural", or items 23a c 19709 524 DUTCH NECK ROAD UNITED STATES Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 1967—
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ş Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) TECHNICIAN U.S. MILITARY event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked HARRY L. GRANTLAND, SR. MYRTLE FAHS ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trau once. JUNE B. GRANTLAND/WIFE 524 DUTCH NECK RD MIDDLETOWN, DE 19709 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
HICKORY
CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Othe (Specify) 10/24/2010 PORT PENN, DE 4 Donation anature of 22. Name and Address of Facility SPICER-MULLIKIN FUNERAL HOME 1000 N DUPONT PKY NEW CASTLE, DE 19720 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): physician Box 68760, Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Vear Day Pregnant at time of death 5 Other (specify) 2 No should be detached the Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has The 2 No To the Hospital or Attending Physician: Th within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral second to the fu 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury 1 □ Yes 2 □ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

• G

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

		For State Registrar	State o	of Marylan		artmen rtificat				lental Hy	giene Reg. No.	010	3649	90
		Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		3. Time of	Death
Physicia /Medic		William Ridge	Gilley							Novemb	er 4,	, 20 ^{Year}	11:5	5a [™]
Examin		4a. Facility Name (If not institution	n, give street and nu	imber)		4b. City,	Town, or	Location	of Death		4c. (County of De	ath	
		Elkton Care and	Rehab			E1kt						eci1		
Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir (Month, D	av Year)	1 (irthplace (State of Country)	r Foreign
Director		216-01-7310 Usual Residence of Decedent	CET IVI CET		92 Yrs.					Nov. 2	7, 19	91/	MD	
land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside Cit	ty Limits
Mary -f sh	ţ	MD Cecil	_	Ris	ing Su	in						1 □Yes 2 📉 No		
r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	Country?	
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ems deat	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes or No Rican, etc.))- 1	4. Race - An Black, Wh	nerican Indian,	
or it		1 Never Married 2 Mar	If Yes, G	ive		1 □ Yes		Specify		, , , , , , , , , , , , , , , , , , , ,			White	
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filed Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)					18. Moth	er's Nam	e (First, Middle	, Maiden S	Surname)		
lid be fenta rked ric ev	To B	George Albert	Gilley Sr	•				Sadi	е Ма	e Hyle				
2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Examinations to excelled at		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address	(Street	and Numb	per or Rui	al Route Numb	er, City or	Town, State	, Zip Code)	
and 2 salth n 27 i		Ron Schmidt /	Personal_						g Su	n, MD 2	1911			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exacting the rediffied at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State 20b. F	Place of Dispo cemetery, crea	osition (Nar matory or o	ne of ther plac	e)	- 1	Date	20c. Loc	cation - City o	or Town, State	
Pag ment ant: I		4 □ Donation 5 □ Other (S		Me Me	adow R	idge	Ceme	tery	11/	9/2010	E1kı	cidge,	MD	
permit. Depart Import any Inj once.		21. Signature of Funeral Service	Licensee		R R	2. Name ar	d Addres	ss of Facil Fun	era1	Home,	P.A.			
□□ = α Ο		Jani 4.7	h	h	1	11 S.	Que	en S	t. R:	ising S	un, M	ID 219		
•	4	2 a. Part 1. Enter the rise e.e, or shock, or heart failure. List	only one cause on e	caused the deat each line.	h. Do not en	ter the mod	le of dyin	ig, such as			irrest,		Approximate Interval Bety Onset and D	ween
Physician		immediate Cause (Final disease or condition resulting in death)	a	ONGE.	STIUL	2 F	EA	MT	MA	LURE				
/Medical Examiner		roouning in account		(or as a conseq		100	7							
	e.	Sequentially list conditions,	b. Due to	17 Po T	カー (に)	Mile	>							
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· la	a Account										
exec in and ial-tra	Exa	resulting in death) Last	C. Due to	(or as a conseq	uence of):			1000	rucy.					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 thours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		d											
ng ph as tt	a l	IF FEMALE:												
th ce tendi r use	an/	23b. Was decedent pregnant in the past 12 months?		tcome of pregna		☐ Ectopic p	regnanc	v			2	3d. Date of d	,	/o.o.r
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ires ti signe	b	Tart II. Other significant contain	one continuoning to a	catt but not res	unang in the u	indonying o	adoc givi	on mr an	1.	772			V	Jnknown
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has Je 2 s	E I	-								24a. Was auto		prior to death	autopsy findings a o completion of ca	ause of
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ath. r: Aft	aţio	1 Natural 5 Pendin 2 Accident investi	9	nth, Day, Year)	Injury	м	Work 1 □	۲۲ Yes 2□]No					
Atte	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	e of injury - At ho		reet, factor	, office				Street and	Number or	Rural Route Num	ber,
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lospi 4 hou iuner ely fill			ng Physician: To the Examiner: On the b)
the h	Medical	one)		nner stated.		200	Licens	o number			00-1 D-14	i	nth Day Veas	
5 <u>≱ 5</u> §		29b. Signature and title of certifie				29		e number			zau. Date	s signed (MO	nth, Day, Year)	
		<u> </u>				5	<i>U</i>		, 3,			11-8	- 2010	
5		30. Name and address of person		se of death (Iten	n 23a) (Type, 1 7.	Print)	ast	111	411	5 meel	- 1	= luls	-2010 n MD	2192
Sta	te	31. Date filed (Month, Day, Year)	/ 32. F	Registrar's Signa										
Registra		NOV 0 8 2010	12 march	Registrar's Signa	backer									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hamilton October 27, 2010 Luretta 6:45 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Woodside Genesis Rehab. Center Silver Spring Montgomery 5, Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 25, 1950 1 🗆 M 2 🝊 F Months Days Hours Min. Jamaica 220-69-5262 60 Director Usual Residence of Decedent Baltimore, Maryland 21215-0036

Formit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 🗆 Yes 2 🏲 No MD P.G. Hyattsville 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 7616 Riverdale Road 20784 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 X Never Married 2 Married Black 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Sydney A. Hamilton Mary L. Stewart 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7616 Riverdale Road, Hyattsville, MD 20784 Andrew Nembhard/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Nov. Metropolitan Crematory Alexandria, VA 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Francis J. Willis Funeral Home Inc. 500 University Blvd. W., silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bhysician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iii ijury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Yes 2 🙀 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Colon Cancer, Jaundice 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv performed Yes 2 death? After this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57630 November 1, 2010 Um 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anuradha Arun, MD 10301 Georgia Avenue, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature faces State NOV 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Firme of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 24 October 2 0 1 0 10:05 am Russell H. Habermehl Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olneu Montgomery 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 💢 M 2 🗆 F Months Days Hours Min (Month, Day, Year) Au 04, 1929 **Director** 217-32-4227 May Usual Residence of Decedent show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1622 Maydale Drive 20905 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. þ 1 Never Married 2 W Married X Yes 2 No Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates WWII White er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Banker Banking of Health and Defiled wof Health and Mental Hygin fritem 27 is marked other rother traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russell Henry Habermehl, Sr. Louanna Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Joy Habermehl - Spouse 1622 Maydale Drive. Silver Spring. Maryland 20905 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/02/2010 | Brentwood, Maryland 21. Signature of Funeral Service Licensee No #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Acute Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pulmonary Embolism 12 ho<u>urs</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: the burial-tr-nsit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed Bilateral Aspiration Pneumonia 48 hours and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Right Middle Cerebral Artery Stroke 8 days Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Bacteremia 1 Yes 2 No 3 Probably 4 X Unknown been 24b. Were autopsy findings available Atrial Fibrillation 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 🗓 No has page 2 After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 🕱 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Accident Investigation filled in by the 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

0+

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Alexander Kinnaird,

MOV 03 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Registrar's Sign

Registrar DHMH 17 Rev 7/2009

State

29c. License number

D68657

18101 Prince Philip Drive, Olney, Maryland 20832

29d, Date signed (Month, Day, Year) 11/1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				ent of Health and M	•	2
		1 - For State Of Marylar Registrar	*	ate of Death	Reg. No	/ H H H 3 h L 4 3
4		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	3. Time of Death
Physic /Medi		Leila Murray Hega	myer		11 03	
Exami		4a. Facility Name (If not institution, give street and number)	4b. C	ity, Town, or Location of Death	40	. County of Death
		5. Social Security Number 6. Sex 7. Age (in yrs.	(ast highday) If Ur	der 1 Year If Under 24 Hrs.	8. Date of Birth	- redenice
Funeral Director		7/11 1-1 5/10 10M 28F	Yrs. Mont		(Month, Day, Year	9. Birthplace (State or Foreign Country) North Carolina
		Usual Residence of Decedent				
Irylan how	_	,	ity, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Be-f	cto	Maryland Frederick	Adams		140.00	
with the	by Funeral Director	10e. Street and Number	10r.	Zip Code 21710		tizen of What Country?
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72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U (Give kind of	work done during most of working	16b. k	Cind of Business/Industry
Men.	I de	Elementary/Secondary (0-12) College (1-4or 5+)		T use retired)		Or m. Hama
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2 shoul and Ma is mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Street and Number or Rura	I Route Number, City	or Town, State, Zip Code)
C 0 2		Glenn Hegamyer/son	5609 Etz	ler Road Fred	erick, Mar	yland 21702
of He of He of the man		20a. Method of Disposition 20b.	Place of Disposition (cemetery, crematory	Name of Dorother place)	ate 20c. L	ocation - City or Town, State
mit. Pages bertment of i ortent: If It ortent: If It		1 ☐ Burial 2 Coremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fina	l Journey	Crematory 11/6	/2010 Woo	odbine, Maryland
permit. Pages 1 end. Deperment of Health Importent: If Item 27 eny injury or other tr		21. Signature of Funeral Service Licensee	Going	and Address of Facility THome Cremation	n Service,	P.O. Box 784 arksville, MD 21029
1 20539		Marchardt, O FF 101/100				Approximate Approximate
		23a. Part Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not enter the r	node of dying, such as cardiac d	r respiratory arrest,	Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				
Examiner		Due to (or as a conse	quence of):			
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	quence of):			
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be exersiclen are burial-t	EX	resulting in death) Last Due to (or as a conse	quence of):			
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law reles be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
the cate h	Son				performed? 1 ☐ Yes 2 🛣 N	death?
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Atternation of the part of the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be building, etc. (Special Could not be building, etc. (Special Could not be building).	nome, farm, street, fac	ctory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number,
safte or in be	Ceri	Building, old (open	.,,			-,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only Medical Examiner: On the basis of examin	address of the contract of the	After the manufacture of a set of the con-		d -td dire to the correct-)
thin 2 the mplet	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
F 3 F 8		mo		00058726		11-4-2010
		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)			11 1 1010
7		Vivitie Warren mo 3000-D	Ventre C	29c. License number 29c. Dicense number 29c. Augusticht	mo 2177	7-3
St		31. Date filed (Month, Day, Year) NOV 0 5 2010 32. Pégistrar's Sign	ature	, ,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #768 Per FH C910 12/08/10 JH of Health and Mental Hygions

			1 - State O	rmarylar	•	rtment of F tificate of	lealth and N <i>Death</i>	-	giene Reg. No.2	010)	36494		
	Dhyoisi		1. Decedent's Name (First, Middle, Last)						Date of Death Month Day Year			3. Time of Death		
	Physici /Medio		Frances T. Harkowa					Nov	12	201		4:25 PM		
	Examin	er	4a. Facility Name (If not institution, give street and nu	m <i>ber)</i>		4b. City, Town, o	r Location of Death		4c. County of Death					
1			Genesis HealthCare				ston	La Duta (Dia		Tal				
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🕅 F	7. Age (In yrs.	95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Sept 1	6 4191 5 191) (Count	ace <i>(Stat</i> e or Foreign ry) York		
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ation					10	d. Inside City Limits		
	Marylan -f show	ţ	Maryland Caroline	р	reston							1 □Yes 2X No		
	r 28a	Director	10e. Street and Number		rescon	10f. Zip Code			10g. Citize	en of What	Count	ry?		
	3a o		20751 Ewing Road			2165	55		USA					
	death	Funeral	11 Marital Status 12 Was Dece	edent Ever in U	J.S. 13. \		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		4. Race - Ar				
Harkowa 21215-0036	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinational Lear Liftled in traumatic event, the Madical Examination is a continuation of the contract of the madical Examination is a contract of the madical Examination is a contract of the madical Examination in the madical Examination is a contract of the madical Examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the madical examination in the madical examination is a contract of the	by	Armed For 1 Never Married 2 Married 1 Yes If Yes, Gi Year or Divorced	ve		Yes, specify Cuba	Specify:	nican, etc.)		Black, Wh Specify: [vite, ei Vhi			
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and	wild be f Mental I arked of atic eve	Be C	Benjamin Murell				Madeli	,		arriamo)				
France e, Maryla	2 should be and Mental is marked c raumatic ev	우	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	a Address (Street	and Number or Rui			Town, State	e. Zip	Code)		
Eg.	and 2 sealth are n 27 is		Joseph Harkowa/ son				oad: Pres							
Ē ē,	s 1 and 3 4 Health Item 27 other tr	- 3	20a. Method of Disposition	20b. I		sition (Name of patory or other place		Date		ation - City				
E 0	Pages nent of int: If Ite		1 A Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)				ery	19 2010	Huds	on, N	ew	York		
Frances Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licensee		22	. Name and Addre	ss of Facility							
			Fleegle and Helfenbein Funeral Home. PO Box 160: Greensboro, Maryland 2163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	Physician		shock, or heart failure. List only one cause on e	ach ine.	+ feil	ure to 1	thrive-					Interval Between Onset and Death		
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687	rtificate ng phy as the	edical	d								1			
Вох	eath cert attending for use a	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, out	come of pregn	ancy	C			23	3d. Date of	delive	ry		
O. B	e death the atte	Physician/M	in the nast 12 months?	oirth 2 Feta nant at time of o own		Ectopic pregnand Other (specify) _	у			Month		Day Year		
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Division of Vital Records,	quires in sign	d by						10	Yes 2□	No 3□	Proba	ably 4 Unknown		
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n o	ding Ph After th funeral	ü		of Injury th, Day, Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe	how injury	occurred				
sio	ttendi death. tor: / the fu	cati	2 Accident investigation				Yes 2 □No							
Divi	al or Attendi s after death. I Director: A d in by the fu	Certification:	4 Homicide determined 28e. Place buildi	ng, etc. <i>(Speci</i>	ome, tarm, stre ify)	et, factory, office		City or To	Street and wn, State)	Number or	Hurai	Route Number,		
	Hospita 4 hours Funera tely fille	Medical C	29a. Certifier (Check only one) Quantum (Check only one)	asis of examina	owledge, death ation and/or in	occurred at the ti	me, date and place ppinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner place, and c	r as st	ated. the cause(s)		
	To the vithin 2 To the comple	Mec	29b. Signature and title of certifier	ner stated.		29c. Licens	e number		29d. Date	signed (Mo	onth, L	Day, Year)		
	⊢≯⊨ő) ///K	9/			177.49	35	/	1.10	5.11	2		
			30. Name and address of person who completed cause	Cic	m 23a) (Type, I	Print)	LANI	FAC	1 mai	MV	, ,	2160		
	Sta	te	31. Date filed (Month, Day, Year) NOV 1 5 2010	egistrar's Signa	and T	LIMH NS	VIIIA		100	1 4		0.10-1		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 MICHAEL. JEFFER(:45 AM Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PG ItyAtts VILLE MURE 4922 LASALLE ROAD THOMAS If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day North Carolina 59 Director Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director none DC SHELTER 120 WASHINGTON 1 😾 Yes 2 🗆 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ING RAGTAM Funeral 20011 WSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Laborer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk ည Barbara Jean Jeffers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Patterson (Mother) 10112 Phoebe Lane Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Ft. Lincoln Cemetery 11/08/2010 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3447 14th Street, N.W. 21. Signature of Funeral Service Li 20010 H. Bacon Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatto Ce year disease or condition Medical resulting in death) Due to (o) as a consequence of): Examiner Sequentially list conditions, if any, leading to in recliate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of). attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nse es, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Human Immunocles Gener Virus /ALDS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Severe Ascites autopsy performed? Yes 2 No has page 2 certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 M Nursing Home 5 A Residence 6 A Other (Specify) Hospital 2 📝 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical KCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

the within 2

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only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

recording Rel Higatise He MD 20181

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KEYSER Month HERBERT LEW 6.50 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLOTTE CHARLOTTE HALL VETARANS HOME HALL ST MARYS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 - 28 - 1 920 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Virginia Director 225-01-7781 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The strain of items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Mexifeal Examiner must be notified at other traumatic event, the Mexifeal Examiner must be notified at 10a. State Completed by Funeral Director 1 🗌 Yes 2 🔀 No Charlotte Hall MD St. Mary's 10e. Street and Numbe 10g. Citizen of What Country? USA 20622 29449 Charlotte Hall Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced 1941 Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Bldg. HVAC Steam Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Esther Victoria Harold Lewis Keyser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Andrew Court, Owings, MD Sylvia C. Keyser, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery | 11-08-2010 | Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE TO THRIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DEMENTIA BODY EWY Sequentially list conditions, Examiner Due to jor as a consequence of if any, leading to himself cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation, Charonic Obstructive 1 Yes 2 No 3 Probably 4 M Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Hypertension, chamic kidney page 2 s autopsy performed' ouisease Yes 2 No 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify ပု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Investigation within 24 hours after des To the Funeral Director completed filled in by th 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MD D0064324 1 hopen of 1120,0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, mp, 20678 1+1 Santha 100 Hospital 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa			Mental Hygie	ene				
			Registrar	tificate of E	Death	2. Date of Death	g. No. 2	36497			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Benjamin KRAUSE			31°, 201°°	3. Time of Death 7:04 A M				
100	Examin		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Silver			4c. County of Dear				
	Funeral		Social Security Number 6. Sex	If Under 1 Year Months Days			9. Bir	thplace (State or Foreign			
	Director		083-32-1169		Tiodic IIII	Feb. 17,	<u> 1920 Ръ</u>	o Tand			
	yland f shov ed at	tor	10a. State 10b. County 10c. City, Town or Loc				1	10d. Inside City Limits V			
	e Mar r 28a- notifie	by Funeral Director	Maryland Montgomery Silver S					1 🗆 Yes 2 🗀 No			
	ith th	ral		10f. Zip Code		10	g. Citizen of What Co	J.S.A.			
	ems ar mus	nue	1131 University Blvd. West #1006 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	209 Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-					
98	fter de ', or it amine		1 Never Married 2 M Married 1 Yes 2 M No	Yes, specify Cuba ☐ Yes 2 🚺 No		to Rican, etc.)	Black, White, etc.				
Š	ours a atural	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of R									
215	n 72 h an "na Medi	Completed	(Specify only highest grade completed) (Give ki	ind of work done of NOT use retired)	during most of wo	rking	6b. Kind of Business	Industry			
21	d withi ygiene her th nt, the	Be Co	12 Ca	rpenter			Carpentry	/			
land	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merikeal Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last) Israel Krause			me (First, Middle, Mai ocheved	Gavron				
Mary	should thand N 7 is ma trauma					ıral Route Number, Cı		o Code)			
re,	f Healt item 2 other	l j	20a. Method of Disposition 20b. Place of Dispos	sition (Name of		nsington,	MD 20895 Oc. Location - City or	Town, State			
<u>=</u>	Page ment o ant: If ury or	3	4 Donation of Other (Specify) Mt. Lebano	atory or other plac n Cemetei	rv Nov.	2. 2010 A	delnhi MC)			
Balt	permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", of any injury or other traumatic event, the Merikeal Examone.		4 Donation of Other (Specify) Mt. Lebanon Cemetery Nov. 2, 2010 Adelphi, MD 21. Signature of Fuviral Pervisor Licenses 22. Name and Address of Facility Torchinsky Henrew Fu 254 Carroll St., NW Washington, DC								
	-		23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one gause on each line.	the mode of dying	g, such as cardiad	or respiratory arrest		Approximate Interval Between			
-	Pnysician/ Medical	8 8	Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic (Coronary	Heart D	isease		Onset and Death			
	Examiner	L	Due to (or as a consequence oi).								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to thin ediction cause. Enter Underlying Cause (Disease or linjury								
	ate be executed hysician and the burial-transit	I Exa	that initiated events c. Due to (or as a consequence of):								
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88	certific anding use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □	Ectopic pregnanc			23d. Date of del	livery			
. Bô	ie death the atte	Physician/Me		Other (specify)	·y		Month	Day Year			
P.0	s that th gned by se detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
rds,	equires een sig nould b	eted	Throat Cancer					robably 4 🕅 Unknown			
3eco	Physician: The law r this certificate has b al director, page 2 sh	Completed			-	24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of			
<u>e</u>	sian: T		25. Was case referred to medical examiner?	26. Pla	ace of Death (Che		_ 10[1 _ 163	2 110			
⋛	Physic this ce al dire	မ	1 ☐ Yes 2 💢 No Hospital: 1 ☐ Inpatient 2 🛣 ER/Outpatient		4 ☐ Nursing F	lome 5 - Residenc		ify)			
ou o	ending F sath. or: After i he funera	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury work? M 1 1		28d. Describe how	njury occurred				
Division of Vital Records, P.O. Box 687	ial or Attors after de al Directors ed in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	ral Route Number,			
	the Hospital or Attending Physician: The law requires that the death certificate be executed third. House after death. Third House all pirector, there this certificate has been signed by the attending physician and the Funeral Director, the funeral director, page 2 should be detached for use as the burial-transit mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1	nation in my opinio	n death occurred	at the time date and r	dace and due to the	ausa(s) and manner stated			
	To the To the Comple	_	29b. Signature and title of certifier	29c. License	number	29d	. Date signed (Month				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int)	e. e:l	ver Spr	MA	20852			
	Stat	e	31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's, Signature		- 311	2 2 pr	ing ma	902			
	Registra	ır	WUV U3 2010 Comman B. Jan								

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 3. Physician/ 2010 9:48 A M Helen Katel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** oct 27, Year 917 1 □ M 2 🔀 F Months Days Hours Min. 131-14-1810 93 Russia Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director X Yes 2 No Rockville Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 6111 Montrose Road, #417 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the Refugee Agency 12 Translator other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 0 Litinsky I. Hessen Emma Boris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20001 310 O Street, NW Peter Katel/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Journey Crematory 11/8/2010 Woodbine, Maryland re of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽hysician/ Respiratory Failure disease or condition resulting in death) Medical Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2X No the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Division of Vital examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 은 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending work s after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DØØ68160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Registrar
DHMH 17 Rev 7/2009

State

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8600 Old Georgetown Road Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zuzak,

Kimberly B.

05

31. Date filed (Mo.

M.D. 8600 32. Begistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Anne Arundel</u> Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Country) Maryland Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. NOV Month ^{Year)}9<u>66</u> 1 Day, Yrs 215-60-4421 43 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e, Street and Number 10g. Citizen of What Country? Funeral 1212 Sterling Circle 21403 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 Thino If Yes, Give 1 Yes 2X No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced id 2 should be filed within 72 hours saith and Mental Hygiene. n 27 is marked other than "natura er traumatic event, <u>the Medical E</u>. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Handyman Home Improvements Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Lerov Alonzo Kenton, Jr. Gertrude Elaine Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Gertrude Kenton/mother Annapolis, Maryland 21403 permit. Page 1 and 2 Department of Health Important; if item 27 any injury or other to once. 1212 Sterling Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 'inal Journey Crematory 11/6/2010 | Woodbine, <u>Maryland</u> 21. Signurge of Funeral Service I Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part the Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each true. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 ☐ Unknown need 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Ko Hospital: Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, Homicide determined building, etc. (Specify)

Division of Vital Records, P.O. Box 68760

Saltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be al Director: A 24 hours a

the Hospital within 2 3

State

Medical

29a. Certifier

only one) 29b. Signat@re and title of certific

Name and address of

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eaistrar's Sianature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year October 0130 AM Elizabeth Μ. Lewis Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rocky. 11e Grove Adventist Hospita If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye March 19 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** Months Days Hours Min. 95 **Director** 170-14-9078 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 🔀 Yes 2 □ No Gaithersburg Maryland Montgomery ò 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 20877 415 Russell Avenue, # United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 'natural", or δ 1 Never Married 2 K Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kimmerline Arthur L. Schieber Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 415 Russell Avenue, # 516, Gaithersburg, MD. 20877 Thomas E. Lewis/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 11/1/2010 Alexandria, Virginia re of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ myocardial days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Due to or as a consequence of: Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy jo in the past 12 months?
1 Yes 2 Alo Month Day Year Pregnant at time of death Unknown signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cancer 1 Yes 2 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 100 1 🗌 Yes hours after death.

Ineral Director: After this certific of filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNO 1 Propatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide rin 24 hour.
ro the Funeral Decompleted filler. Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the P 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one 29b. Signature ar 31. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20879 R. Melnick MD 911 ssell 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

30 am

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